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| **IN THE MATTER OF** | * | **BEFORE THE** |
| **BASHAR PHAROAN, M.D.** | * | **MARYLAND STATE** |
| **Respondent** | * | **BOARD OF PHYSICIANS** |
| **License Number: D19637** | * | **Case Number: 2219-0077B** |

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## CONSENT ORDER

On November 20, 2020, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") charged **BASHAR PHAROAN, M.D.** (the "Respondent"), License Number D19637, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. §§ 14-101 *et seq.* (2014 Repl. Vol. & 2019 Supp.). Panel B charged the Respondent under the following provisions of the Act:

> **Health Occ. § 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> (a) *In general.* -- 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:
>
> (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; [and]
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

On February 24, 2021, Panel B 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 this Consent Order, consisting of the following Findings of Fact, Conclusions of Law, and Order.

## FINDINGS OF FACT

Panel B finds:

### I. BACKGROUND

1. At all times relevant, the Respondent was, and is, licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on August 9, 1976, under License Number D19637. The Respondent's license is current through September 30, 2021.

2. The Respondent is board-certified in general surgery and at all times relevant, practiced general a health care facility (the "Facility A")[1] in Baltimore, Maryland.

3. The Board initiated an investigation of the Respondent after receiving a Mandated 10-Day Report from Facility A reporting that it had summarily suspended the Respondent's clinical privileges due to concerns regarding his clinical judgment and ability to work with others.

### II. BOARD INVESTIGATION

4. In furtherance of its investigation, the Board obtained thirteen medical records of patients whom the Respondent treated and forwarded them to an independent reviewing agency for a peer review. Two licensed physicians Board-certified in general surgery conducted the review and concurred that the Respondent failed to meet quality

[1] To ensure confidentiality, the names of individuals, hospitals and healthcare facilities involved in this case are not disclosed in this Consent Order.

medical and/or surgical standards in eight of thirteen cases and failed to keep adequate medical records in two of thirteen cases. A summary of the reviewers' findings is set forth below.

## III. PATIENT-SPECIFIC SUMMARIES

### Patient A

5. Patient A initially saw the Respondent in December 2018 for anal pain and rectal bleeding. Patient A had a history of internal hemorrhoids. The Respondent recommended an increase in fiber and water intake along with steroid suppository treatment.

6. When Patient A's symptoms did not resolve, the Respondent performed a colonoscopy but converted it to sigmoidoscopy due to poor preparation. The finding was internal hemorrhoids without any other pathology.

7. In Patient A's medical record, the Respondent documented that Patient A had a history of colonoscopy with a diagnosis of rectal bleeding and that Patient A had no previous colonoscopy with asymptomatic hemorrhoids in the same office note.

8. The Respondent failed to keep adequate medical record, in violation of Health Occ. § 14-404(a)(40), with respect to Patient A when he documented that Patient A had a history of colonoscopy with a diagnosis of rectal bleeding and that Patient A had no previous colonoscopy with asymptomatic hemorrhoids in the same office note.

### Patient B

9. Patient B was referred to the Respondent for evaluation of abdominal pain, chronic diarrhea and anemia. The Respondent recommended endoscopy and colonoscopy,

but Patient B declined the endoscopy. On or about December 19, 2017, the Respondent proceeded with the colonoscopy but converted it to a sigmoidoscopy due to poor preparation. Biopsies done at the time showed acute sigmoid colon inflammation diagnostic of inflammatory bowel disease.

10. The Respondent attempted a second colonoscopy on or about January 31, 2018, during which he observed sigmoid diverticula and internal hemorrhoids. The Respondent recommended that Patient B undergo a colonoscopy in one year, obtain a computed tomography scan of the abdomen and pelvis and follow up with his primary care physician. The Respondent, however, failed to evaluate and treat Patient B's inflammatory bowel disease, instead leaving it up to Patient B to follow up with his primary care physician.

11. The Respondent's recordkeeping was superficial and failed to document a physical examination or Patient B's symptoms.

12. The Respondent failed to meet quality medical and/or surgical care, in violation of Health Occ. § 14-404(a)(22), in his care and treatment of Patient B in that he failed to evaluate and treat Patient B's inflammatory bowel disease as reflected by the biopsy.

13. The Respondent failed to keep adequate medical record, in violation of Health Occ. § 14-404(a)(40), with respect to Patient B in that his recordkeeping was superficial and failed to document a physical examination or Patient B's symptoms.

**Patient C**

14. Patient C presented to the Respondent with severe constipation, right upper quadrant pain, bloating and a history of colonic polyps. The Respondent performed a colonoscopy resulting in removal of a three-millimeter sigmoid colon polyp. Subsequently, the Respondent advised Patient C to increase water and fiber intake and recommended a colonoscopy in two to three years.

15. The Respondent failed to assess and treat Patient C's complaint of constipation, and there was no justification for recommending a colonoscopy in two to three years.

16. The Respondent failed to meet quality medical and surgical standards, in violation of Health Occ. § 14-404(a)(22), in his treatment and care of Patient C for reasons including, but not limited to: failing to assess and treat Patient C's constipation and failing to justify recommending a colonoscopy in two to three years.

**Patient D**

17. Patient D was initially seen by the Respondent for prolapse of the stoma after having had a transverse loop colostomy placed by another surgeon. The Respondent planned an elective stoma revision, but prior to the revision, Patient D presented to the emergency department on July 19, 2017, with prolapse and necrosis of the stoma. The Respondent performed an exploratory laparotomy, resected the ischemic portion of the colostomy, stapled off the distal end and matured the proximal end of the transverse colon as a new colostomy. During the surgical procedure, the Respondent was notified of a missing sponge but elected to close the abdomen. A post-operative radiograph confirmed the presence of the missing sponge within the distal limb of Patient D's colon. On or about

September 1, 2017, the Respondent attempted a colonoscopy to remove the sponge but was unsuccessful. The Respondent finally removed the sponge on or about October 27, 2017, through a colonoscopy.

18. The Respondent should have removed the missing sponge during the same surgical procedure on July 19, 2017, by delaying the closing of or reopening Patient D's abdomen, instead of waiting approximately three and one-half months later.

19. The Respondent failed to meet quality medical and/or surgical care, in violation of Health Occ. § 14-404(a)(22), in his treatment and care of Patient D, when he failed to remove the missing sponge during the same surgical procedure performed on or about July 19, 2017.

**Patient E**

20. Patient E was initially evaluated by the Respondent on or about May 17, 2018, for abdominal distension, weight loss and anemia. Patient E had a history of morbid obesity, atrial fibrillation, chronic kidney disease, valvular heart disease and multiple acral decubiti. An aborted colonoscopy was done on or about May 29, 2017, with no significant pathology noted.

21. The Respondent saw Patient E at her assisted living facility on or about June 14, 2018, after Patient E developed significant abdominal distension. The Respondent tried oral neostigmine without resolution. The Respondent recommended waiting to see if Patient E's abdomen becomes bigger.

22. By June 18, 2018, Patient E's condition remained unchanged, and the Respondent recommended and obtained consent from Patient E's family for a transverse

loop colostomy. Prior to recommending the surgical procedure, however, the Respondent failed to thoroughly work up Patient E's colonic pseudo-obstruction by ruling out mechanical obstruction, determine the diameter of the colon, correct metabolic derangements, attempt neostigmine or attempt colonoscopic decompression.

23. On or about June 22, 2018, the Respondent determined that surgery was too of a risk for Patient E and returned her to the assisted living facility for hospice care.

24. The Respondent failed to meet quality medical and/or surgical care, in violation of Health Occ. § 14-404(a)(22), in his treatment and care of Patient E, when he failed to first thoroughly work up and treat Patient E's colonic pseudo-obstruction prior to recommending and obtaining consent for a colostomy.

**Patient F**

25. Patient F initially saw the Respondent on or about June 28, 2018, with complaints of frequent postprandial vomiting over the past two weeks. Patient F had a history of diabetes, anemia, multiple cerebrovascular accidents and a colonoscopy in 2016. The Respondent recommended blood testing, a Computed Tomography ("CT") scan, gastric emptying scan, an ultrasound and a colonoscopy, which he performed on or about August 13, 2018.

26. The colonoscopy the Respondent performed was not indicated as Patient F did not complain of abdominal pain in her initial visit and had already had a colonoscopy done in 2016.

27. The Respondent failed to meet quality medical and/or surgical care, in violation of Health Occ. § 14-404(a)(22), in his treatment and care of Patient F, when he

performed a colonoscopy on Patient F on or about August 14, 2018, which was not indicated.

**Patient G**

28. Patient G initially saw the Respondent on or about March 16, 2018, after she underwent a colonoscopy, which revealed a 3 cm cecal polyp suspected to be malignant. The Respondent recommended a repeat colonoscopy and a laparoscopic right colectomy, which he performed in August 2018. The Respondent's notes indicated that the repeat colonoscopy was to make sure there was "no change" in the mass.

29. The repeat colonoscopy prior to the laparoscopic right colectomy was unnecessary as there was no reason to evaluate the lesion for change four months after diagnosis.

30. The Respondent failed to meet quality medical and/or surgical care, in violation of Health Occ. § 14-404(a)(22), in his treatment and care of Patient G, when in August 2018 he performed a repeat colonoscopy prior to a laparoscopic right colectomy, which was unnecessary.

**Patient H**

31. Patient H initially saw the Respondent in 2012 after an attack of diverticulitis. The Respondent performed a colonoscopy in October of 2012 where he found diverticula.

32. On or about July 25, 2015, the Respondent performed a repeat colonoscopy on Patient H after he complained of abdominal pain. The Respondent noted a 3 mm polyp in the cecum but was unable to resect it. This repeat colonoscopy the Respondent performed was not indicated based Patient H's complain of unspecified abdominal pain.

Once the Respondent discovered the polyp but was unable to resect it, he should have followed up later with Patient H to attempt to remove the polyp.

33. On or about July 9, 2018, the Respondent performed another repeat colonoscopy on Patient H, which was not indicated, that resulted in no significant finding aside from diverticulitis and hemorrhoids.

34. The Respondent failed to meet quality medical and/or surgical care, in violation of Health Occ. § 14-404(a)(22), in his treatment and care of Patient H, when he performed colonoscopies on Patient H in 2015 and 2018 that were not indicated. After the Respondent discovered the 3 mm polyp in the 2015 colonoscopy but was unable to resect, the Respondent should have followed up with Patient H to attempt to remove the polyp.

**Patient I**

35. Patient I initially saw the Respondent on or about March 14, 2018 and recommended a screening colonoscopy since Patient I's last colonoscopy was over ten years prior. On or about April 16, 2018, the Respondent performed the colonoscopy but noted that the preparation was poor. Despite noting that the preparation was poor, the Respondent recommended a repeat surveillance colonoscopy in three years instead of three months.

36. The Respondent failed to meet quality medical and/or surgical care, in violation of Health Occ. § 14-404(a)(22), in his treatment and care of Patient I, when he recommended that Patient I undergo a repeat surveillance colonoscopy in three years despite noting that the preparation was poor in the last colonoscopy.

## CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel B concludes as a matter of law that: the Respondent 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 location 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 thus, by an affirmative vote of a majority of the quorum of Disciplinary Panel B, hereby:

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

**ORDERED** that the Respondent is placed on **PROBATION** for a minimum of **FIFTEEN (15) MONTHS.**[2] During probation, the Respondent shall comply with the following terms and conditions of probation:

(1) Within **THREE (3) MONTHS** of the effective date of this Consent Order, the Respondent is required to take and successfully complete a course in medical record-keeping. The following terms apply:

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

(b) The disciplinary panel will accept a course taken in-person or over the internet during the state of emergency;

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

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

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

(e) The Respondent is responsible for the cost of the course.

(2) **SUPERVISION:** The Respondent shall be subject to supervision by a disciplinary panel-approved supervisor who is board-certified in general surgery with a sub-specialty in colorectal surgery.

(a) Within **THIRTY (30) calendar days** from the effective date of this Consent Order, the Respondent shall provide the disciplinary panel with the name, pertinent professional background information of the supervisor whom the Respondent is offering for approval, and written notice to the disciplinary panel from the supervisor confirming his or her acceptance of the supervisory role of the Respondent, and that that there is no personal or professional relationship with the supervisor;

(b) The Respondent's proposed supervisor, to the best of the Respondent's knowledge, shall not be an individual who is currently under investigation, or who has been disciplined by the Board within the past five years;

(c) If the Respondent fails to provide a proposed supervisor's name within 30 days from the effective date of this Consent Order, the Respondent's license shall be automatically suspended from the 31st day until the Respondent provides the name and background of a supervisor;

(d) The disciplinary panel, in its discretion, may accept the proposed supervisor or request that the Respondent submit the name and professional background, and notice of confirmation, from a different supervisor;

(e) The supervision begins after the disciplinary panel approves the proposed supervisor;

(f) The disciplinary panel shall provide the supervisor with a copy of this Consent Order, and any other documents that the disciplinary panel deems relevant;

(g) The Respondent shall grant the supervisor access to patient records selected by the supervisor, which shall, to the extent possible, focus on the type of treatment at issue in the Respondent's charges;

(h) If the supervisor for any reason ceases to provide supervision, the Respondent shall immediately notify the disciplinary panel and shall not practice medicine beyond the 30th day after the supervisor has ceased to provide supervision and until the disciplinary panel has approved another supervisor pursuant to the process set forth in Paragraph (2)(a) above.

(i) It shall be the Respondent's responsibility to ensure that the supervisor:

1. reviews the records of **TEN (10) patients** each month, such patient records to be chosen by the supervisor and not the Respondent;

2. meets in-person with the Respondent at least **ONCE EACH MONTH** for the duration of the **FIFTEEN (15) MONTHS** supervision period to discuss with the Respondent the care that the Respondent has provided for these specific patients;

3. is available to the Respondent for consultation on any patient;

4. maintains the confidentiality of all medical records and patient information;

5. provides the disciplinary panel with **QUARTERLY** reports which detail the quality of the Respondent's practice, any deficiencies, concerns, or needed improvements, as well as any measures that have been taken to improve patient care; and

6. immediately reports to the disciplinary panel any indication that the Respondent may pose a substantial risk to patients.

(j) The Respondent shall follow any recommendations of the supervisor;

(k) If the disciplinary panel, upon consideration of the supervisory reports and the Respondent's response, if any, has a reasonable basis to believe that the Respondent is not meeting the standard of quality care or is failing to keep adequate medical records in his practice, the disciplinary panel may find a violation of probation after a hearing; and it is further

(3) **ORDERED** that the Respondent shall not apply for early termination of probation; 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 a 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 the Respondent has successfully complied with all of the probationary terms and conditions and if there are no pending complaints related 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 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 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 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).

03/26/2021
Date

***Signature on File***

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

**CONSENT**

I, Bashar Pharoan, 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.

3/23/2021
Date

***Signature on File***

Bashar Pharoan, M.D.
Respondent

## NOTARY

**STATE OF** Maryland

**CITY/COUNTY OF** BALTC

**I HEREBY CERTIFY** that on this 23 day of MAR 2021, before me, a Notary Public of the foregoing State and City/County, personally appeared Bashar Pharoan, 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.

Robin James Davis SR
Notary Public

My Commission expires: 11/7/2022

ROBIN JAMES DAVIS SR.
NOTARY PUBLIC
BALTIMORE COUNTY, MD