IN THE MATTER OF	*	**BEFORE THE**
MOHAMMED M. MOHIUDDIN, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D20015	*	**Case Number: 2221-0078**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of **MOHAMMED M. MOHIUDDIN, M.D.** (the "Respondent"), License Number D20015, to practice medicine in the State of Maryland.

Panel B takes such action pursuant to its authority under Md. Code Ann., State Gov't § 10-226(c) (2014 Repl. Vol. & 2020 Supp.) and Md. Code Regs. ("COMAR") 10.32.02.08B(7)(a), concluding that the public health, safety or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

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

[1] The statements regarding Panel B's investigative findings are intended to provide the Respondent with notice of the basis of the 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.

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 Maryland on December 16, 1976, under License Number D20015. The Respondent's license is current through September 30, 2021.

2. The Respondent is board-certified in urology.

3. At all times relevant hereto, the Respondent is the sole owner and provider at a health care group (the "Health Care Group")[2] located in Frederick, Maryland. The Health Care Group also has a practice location in Charles Town, West Virginia. The Respondent has clinical privileges at a health care facility ("Health Care Facility A") located in Frederick, Maryland.

4. On December 2, 2020, the Board received a Mandated 10-Day Report (the "November 20, 2020 Report") from Health Care Facility A reporting it had imposed a precautionary administrative suspension on the Respondent's privileges, after his performance in two surgical procedures on November 16, 2020. On January 11, 2021, the Board received a subsequent Mandated 10-Day Report (the "December 15, 2020 Report") from Health Care Facility A reporting its investigation into the Respondent was terminated and his clinical privileges were changed to ""Refer and Follow Patients."[3]

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[2] For confidentiality and privacy purposes, the names of individuals and health care facilities involved in this case are not disclosed in this document. The Respondent may obtain the names of all individuals and health care facilities referenced in this document by contacting the administrative prosecutor.

[3] Health Care Facility A filed two Mandated 10-Day Reports, but has not provided the underlying documents such as staff comments and interviews. As a result, the Board has been significantly delayed in its efforts to investigate the allegations related to the November 16, 2020 surgical procedures.

II. BOARD INVESTIGATION

5. On February 19, 2021, the Board received the Respondent's written response to the Mandated 10-Day Reports. In the letter, the Respondent defended his performance during the two November 16, 2020 procedures at issue. The Respondent further stated he elected to change his clinical privileges with Health Care Facility A to "Refer and Follow Patients."

6. As early as June 2020, staff of Health Care Facility A raised concerns regarding the Respondent's demeanor and ability to safely perform surgical procedures.

7. On June 2, 2020, during a procedure to remove a kidney stone and insert a stent, a staff member of Health Care Facility A observed the Respondent apparently unable to see the guide wire via real time on fluoroscopy. The Respondent repeatedly asked a staff member of Health Care Facility A to tell him when the guide wire was in the kidney, and believed the Respondent could not see the wire.

8. On June 4, 2020, during a procedure, a staff member of Health Care Facility A observed the Respondent not visualize a 3x4 cm bladder mass despite passing by it several times with a cystoscope. The Respondent announced he was aborting the procedure when staff of Health Care Facility A pointed that the tumor was "right there." Staff of Health Care Facility A observed the Respondent holding his head to the side to look at the monitor with his right eye only as though the Respondent was compensating for vision issues. These concerns prompted Health Care Facility A to administratively suspend the Respondent from performing surgical procedures and referred the Respondent for a June 10, 2020 medical examination. As a result of the examination, Health Care Facility A

required the Respondent to wear glasses during surgical procedures and removed the suspension on June 11, 2020.

9. On June 29, 2020, the Respondent was observed by staff of Health Care Facility A performing a prostate needle biopsy on a patient. There are 12 pre-labeled specimen cassettes used during the procedure. As each specimen was received from the Respondent, staff of Health Care Facility A confirmed with the Respondent which specimen was received. During this procedure, staff observed the Respondent forgetting what specimens he was giving to staff. When staff confronted the Respondent about the specimen confusion, he stated: "It doesn't matter, just put them anywhere." After staff responded that it "does really matter," the Respondent "ripped" off his gown and gloves and said "he was done," grabbed a patient label and walked out of the room prior to a debriefing. Staff observed that only 10 of the 12 specimens were collected. However, the procedure note authored by the Respondent noted 12 biopsies were taken and that two specimens were placed in containers holding other specimens by staff.

10. On July 9, 2020, Health Care Facility A referred the Respondent to an evaluative program. While awaiting evaluation, the Respondent was placed on precautionary suspension by Health Care Facility A. The evaluation occurred and an Executive Summary issued on August 19, 2020.[4] On or about August 26, 2020, Health Care Facility A reinstated the Respondent's privileges.

[4] The nature of the report is confidential.

11. Thereafter, on November 16, 2020, the Respondent initiated two surgical procedures. The Respondent was unsuccessful in performing the intended procedures, displayed vision and dexterity problems during the procedures, refused to wear his prescription glasses during the procedures, had a visible hand tremor and the procedures took much longer than expected.

12. The first procedure was a left percutaneous nephrectomy with placement of an occlusion balloon catheter in the left ureter. During the procedure, staff of Health Care Facility A observed that for 60-90 minutes the Respondent had difficulty cannulating the patient's ureter and was unable to locate the ureteral orifice in the bladder. This caused trauma to the bladder, resulting in bleeding. The patient was admitted to Health Care Facility A with bladder irrigation for the hematuria.

13. During this first procedure, supervisory staff at Health Care Facility A was alerted that Respondent refused to wear his glasses as required, and the procedure was taking longer than expected. Supervisory staff at Health Care Facility A alerted leadership of the Respondent's actions during the first procedure by text message: "Please call me. We need someone ASAP. He doesn't have his glasses on and won't put them on, because he can't see. The FA [first assistant] and scrub tech are giving him direct guidance. He has a ureter in his hand and can't thread the catheter. He can't see." The Respondent thereafter was directed to wear his glasses.

14. Additionally, during the first procedure, staff of Health Care Facility A observed the Respondent having a visible hand tremor.

15. The second procedure involved a right laparoscopic pyeloplasty the Respondent was unable to complete. During the procedure, the Respondent was unable to thread the catheter and was observed to have difficulty seeing. The staff of Health Care Facility A were concerned about excessive delay of several hours, the inability of the Respondent to thread the catheter and observed vision and dexterity problems, including a visible tremor of the right hand.

16. During the second procedure, staff of Health Care Facility A alerted leadership and supervisory staff of concerns about the Respondent; specifically that he had a visible tremor and they did not feel comfortable with the Respondent continuing the procedure. Supervisory staff and leadership of Health Care Facility A physically went to the location of the second procedure, called a safety timeout and ordered the Respondent to stop the case. Thereafter, arrangements were made for another urologist to complete the procedure to assure patient safety.

17. Leadership at Health Care Facility A stated: "To my observation as having come in later on in the procedure to observe, there was a stent cannulation process that was required for the ureter and the stent was not going into the ureter as planned, it was curling up. And rather than attempt another technique, there was an effort made multiple times to, to do the procedure in the same fashion. And the concern from my standpoint...was the potential injury to the ureter, and so we had a, another urologist come in and successfully assist with that."

18. During the second procedure and after the safety timeout, the Respondent had a visible tremor in his right hand and was supporting it with his left hand across his chest. The procedure took 3 hours longer than planned.

19. On April 28, 2021, Panel B referred the Respondent to a Board-approved program for evaluation pursuant to Health Occ. § 14-402. On May 3, 2021, the Respondent met with staff of the Board-approved program for the intake evaluation. The evaluator determined that "it is not safe for [the Respondent] to practice urological surgery at this time."

CONCLUSIONS OF LAW

Based upon the foregoing Investigative Findings, Panel B concludes as a matter of law that the public health, safety, or welfare imperatively requires emergency action, pursuant to Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol. and 2020 Supp.) and Md. Code Regs. ("COMAR") 10.32.02.08B(7)(a).

ORDER

It is, by a majority of the quorum of Panel B, hereby:

ORDERED that pursuant to the authority vested in Panel B by Md. Code Ann., State Gov't § 10-226(c)(2) and COMAR 10.32.02.08B(7)(a), 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 COMAR 10.32.02.05B(7) on the summary suspension will be held on **Wednesday, May 26, 2021,**

at 1:00 p.m. before Panel B at the Maryland State Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215-0095; and it is further

ORDERED that at the conclusion of the post-deprivation hearing before Panel B, the Respondent, if dissatisfied with the result of the hearing, may request within ten (10) days an evidentiary hearing, such hearing to be set 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 a copy of this Order for Summary Suspension shall be filed with the Board in accordance with Health Occ. § 14-407 (2014 Repl. Vol. and 2020 Supp.); and it is further

ORDERED that this is an Order of Disciplinary Panel B, and as such, is a **PUBLIC DOCUMENT.** *See* Md. Code Ann., Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Provisions § 4-333(b)(6).

Signature on File

05/14/2021
Date

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians