IN THE MATTER OF	*	**BEFORE THE**
WILTON NEDD, M.D.,	*	**MARYLAND STATE**
Respondent.	*	**BOARD OF PHYSICIANS**
License Number: D39795	*	**Case Numbers: 2219-0019A**

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FINAL DECISION AND ORDER

PROCEDURAL HISTORY

Wilton Nedd, M.D., is a physician practicing vascular surgery, originally licensed to practice medicine in Maryland in 1990. On July 6, 2020, Disciplinary Panel A of the Maryland State Board of Physicians (the "Board") charged Dr. Nedd with failure to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care ("standard of care") and a failure to keep adequate medical records as determined by appropriate peer review. *See* Md. Code Ann., Health Occ. § 14-404(a)(22), (40).

On April 6, 7, 8, and 16, 2021, an Administrative Law Judge ("ALJ") held an evidentiary hearing at the Office of Administrative Hearings. On July 6, 2021, the ALJ issued a proposed decision concluding that, for Patient A and Patient C, Dr. Nedd failed to meet the standard of care, in violation of Health Occ. § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40). As a sanction, the ALJ recommended a stayed suspension, two years of supervised probation, a restriction for on call or emergency procedures in a hospital setting while on probation, a professional competency evaluation, a recordkeeping course, and a $5,000 fine. The ALJ recommended dismissing the charge of inadequate recordkeeping, *see* Health Occ. § 14-404(a)(40), for Patient B.

The State and Dr. Nedd filed exceptions to the sanction in the ALJ's proposed decision. The State also took exception to the ALJ's dismissal of a recordkeeping violation for Patient B. Dr. Nedd did not take exception to the ALJ's findings of fact or conclusions of law. On September 15, 2021, both parties appeared before Disciplinary Panel B of the Board for an exceptions hearing.

FINDINGS OF FACT

The Panel adopts the Stipulated Facts ¶¶ 1-21 and the ALJ's Proposed Findings of Fact ¶¶ 22-74 and incorporates them by reference into the body of this document as if set forth in full. *See* attached ALJ Proposed Decision, Exhibit 1. The Panel also adopts the ALJ's discussion section in full (pages 15-39) with the exception of the second full paragraph on page 29, which is not adopted. Ex. 1. The findings of fact were proven by the preponderance of the evidence.

ANALYSIS

Failure to meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care - Health Occ. § 14-404(a)(22))

Disciplinary Panel A charged, and the ALJ found, that Dr. Nedd failed to meet the appropriate standard of care for Patient A and Patient C.

Patient A

The ALJ found and the Panel upholds a finding of a violation of the standard of care for Patient A. Patient A was admitted to the emergency department on May 26, 2014, for an acute myocardial infarction[1] with near total occlusion[2] of the right coronary artery and underwent a right transfemoral cardiac catheterization[3] to implant five right coronary stents to achieve normal blood

[1] Myocardial infarction is the injury or death of heart tissue as a result of inadequate blood supply.
[2] Occlusion is an obstruction.
[3] Transfemoral cardiac catheterization is a procedure whereby a long, thin, tube (a catheter), is inserted into the femoral artery of the leg to gain access to the vascular system and ultimately, the heart.

flow to the heart. Additionally, a femoral artery Angio-Seal[4] device was used as a plug to prevent further bleeding. On June 2, 2014, Patient A returned to the emergency room with signs of sepsis[5] (nausea, vomiting, diarrhea, and a fever with chills) due to an infected right groin hematoma.[6] Dr. Nedd was called for a consult and met with Patient A. On June 3 2014, Dr. Nedd performed an exploration of Patient A's right groin, a thrombectomy[7] of the right superficial femoral artery with ligation,[8] and partial resection of the common femoral artery after finding an infected hematoma caused by the Angio-Seal.

The State's expert explained that the standard of care requires the use of a Doppler scan[9] to inform the surgeon whether there is any blood flow to the extremity following the ligation procedure that Dr. Nedd performed on Patient A. Dr. Nedd failed to perform a Doppler scan after performing a ligation procedure for Patient A, violating the standard of care.

The ALJ also found that Dr. Nedd improperly delayed a second surgery for ischemia[10] of Patient A's foot. Specifically, Dr. Nedd claimed that Patient A's conditions of septic shock and coronary artery disease prevented him from performing bypass surgery immediately after the ligation procedure and that he needed to delay surgery until he had the results from an imaging test. The State's expert testified that the standard of care required that Dr. Nedd perform an MRA (Magnetic Resonance Angiogram)[11] while Patient A was on the operating table. While Dr. Nedd

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[4] An Angio-Seal is a vascular closure device used to secure a puncture site.
[5] Sepsis is a potentially life-threatening condition caused by an imbalance of chemical released by the body to fight infection.
[6] Hematoma is a collection of blood outside of a blood vessel.
[7] Thrombectomy is a type of surgery to remove a blood clot inside an artery or vein to allow blood to flow.
[8] Ligation is the act of tying a blood vessel with a piece of thread or wire that prevents blood flow to areas supplied by the vessel.
[9] Doppler signals are used to measure the amount of blood flow in a given area of the body.
[10] Ischemia is lack of blood flow and oxygen.
[11] MRA is a test in which radio waves, a magnetic field, and a computer are used to image blood vessels.

blamed emergencies in the operating room, the summary of the Medical Executive Committee summary revealed that Dr. Nedd conducted another surgery that same afternoon. The expert testified that Dr. Nedd should have pushed for this emergency surgery on Patient A to take precedence. Patient A eventually had surgery that required amputation of Patient A's foot.

Moreover, the ALJ found that Dr. Nedd failed to obtain proper informed consent prior to Patient A's first surgery because he did not include the possibility of a bypass procedure in the consent form. The State's expert explained that that the consent form should have included a bypass as a possibility during the initial exploratory surgery and ligation. Dr. Nedd testified that he discussed it with the family before the surgery. The ALJ agreed with the State's expert and found that Dr. Nedd should have included the bypass in his consent form.

The Panel agrees with the ALJ's findings related to Patient A and concludes that Dr. Nedd violated the standard of care with respect to his care of Patient A, in violation of Health Occ. § 14-404(a)(22).

Patient C

Patient C was a seventy-four year old with a complex medical history. On August 2, 2017, Dr. Nedd performed an elective placement of a loop dialysis graft on Patient C's right thigh. On August 12, 2017, Patient C was readmitted with vomiting, dark stools, and hypotension during dialysis. Nurses noted thigh wounds and broken blisters. Patient C was discharged on August 18, 2017. On August 21, Patient C was readmitted with an infected graft in her right groin that Dr. Nedd has inserted earlier that month. Dr. Nedd discussed Patient C's medical condition with her over the telephone but based on the emergency department doctor's observations, concluded that Patient C did not have a necrotizing infection or sepsis and decided to wait until the next day to examine her.

The State's expert determined that it was a violation of the standard of care to fail to personally examine Patient C for signs of sepsis and necrotizing fasciitis and that relying on the emergency department physician when she was admitted was insufficient. The expert also testified that, once a patient presents with an infected graft, the graft needs to be removed and that Dr. Nedd violated the standard of care by waiting three days before removing the graft. Finally, the State's expert raised concerns about Dr. Nedd's familiarity with an infected thigh wound that was mentioned in the patient's medical record.

The ALJ found that Dr. Nedd violated the standard of care in connection with Patient C by: (1) failing to actively monitor Patient C, a critically ill patient with known risk factors, for developing gangrene; and (2) failing to consult the daily chart wound assessment and treatment notes prepared by hospital staff. The ALJ concluded that Dr. Nedd had the responsibility to be familiar with the nursing notes. Based on these facts, the ALJ found that Dr. Nedd violated the standard of care for Patient C, in violation of Health Occ. § 14-404(a)(22).

Neither party disputes these findings for Patient A and Patient C. The Panel finds that Dr. Nedd's treatment of Patient A and C did not meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care. *See* Health Occ. § 14-404(a)(22).

Failure to keep adequate medical records as determine by appropriate peer review
Health Occ. § 14-404(a)(40)

Disciplinary Panel A charged that Dr. Nedd failed to keep adequate medical records for three patients, Patients A, B, and C.

Patient A

For Patient A, on the day before the surgery, Dr. Nedd's report only mentioned checking Patient A's right groin. His report did not document checking for pedal pulse or documenting the appearance of the feet for comparison the next day. Further, Dr. Nedd's notes regarding the day of the second surgery were difficult to decipher, and the ALJ found them difficult to understand with respect to whether he examined Patient A. Based on these issues demonstrating deficient records, the ALJ found a violation for keeping inadequate medical records, *see* Health Occ. § 14-404(a)(40).

Patient C

For Patient C, Dr. Nedd's notes stated that Patient C's thigh wound was not seen at the time of admission. The ALJ found it misleading or incorrect because the note implied that Dr. Nedd did not know about the wound until the surgery. In fact, he was told about the wound on the day before the surgery. The Panel adopts the ALJ's analysis and finds that Dr. Nedd's medical documentation related to the thigh wound was inadequate and violated Health Occ. § 14-404(a)(40).

Neither party objected to the findings pertaining to Patient A and C. The Panel agrees with the ALJ's findings related to Patient A and Patient C and concludes that Dr. Nedd kept inadequate medical records, in violation of Health Occ. § 14-404(a)(40).

Patient B

Patient B, an eighty-four-year-old was admitted to the emergency department after losing consciousness. On January 10, 2017, Dr. Nedd performed a right carotid endarterectomy with patch angioplasty, opening the carotid artery to remove blockages. Patient B developed a neck

hematoma with stridor.[12] The next day, Dr. Nedd performed a surgery to evacuate Patient B's neck hematoma. Dr. Nedd did not place a drain during the surgery and did not record doing so in his medical records. During its investigation, the Board asked Dr. Nedd to provide a summary of care. In that summary, Dr. Nedd erroneously stated that he placed a drain. Dr. Nedd testified that he intended to write that he placed a dressing and mistakenly wrote that he placed a drain. The ALJ found that Dr. Nedd was believable that he meant to write that he placed a dressing and not a drain and that this unintentional error indicated sloppiness rather than dishonesty. The State filed exceptions to the findings of the ALJ pertaining to Patient B. The State argues that the contradictory statements indicate a lack of honesty.

The Panel adopts the ALJ's conclusion. It is undisputed that the medical records kept by Dr. Nedd accurately recorded that he did not place a drain. The Panel declines to find that the inconsistent explanation to the Board demonstrates a recordkeeping violation. The Panel adopts the ALJ's finding that his incorrect summary to the Board is a result of sloppiness rather than a lack of candor. Further, the summary was provided to the Board as part of its investigation and was thus not part of his contemporaneous medical documentation. It had no potential for harm because it would not have been reviewed by a subsequent practitioner. The Panel, however, cautions Dr. Nedd that he must be careful in his communications with the Board. In any event, the Panel dismisses the charge of inadequate medical recordkeeping concerning Patient B. *See* Health Occ. § 14-404(a)(40).

[12] Stridor is an abnormal, high-pitched sound produced by turbulent airflow through a partially obstructed airway.

CONCLUSIONS OF LAW

Disciplinary Panel B concludes, as a matter of law, that Dr. Nedd failed to meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care in this state concerning Patient A and Patient C, in violation of Health Occ. § 14-404(a)(22), and that he failed to keep adequate medical records as determined by appropriate peer review, in violation of Health Occ. § 14-404(a)(40) for Patient A and Patient C.[13] The Panel dismisses the charge of inadequate medical records concerning Patient B.

SANCTION

As a sanction, the ALJ recommended that Dr. Nedd be sanctioned with a stayed suspension, two years of probation, supervision during the probationary period, a prohibition on performing emergency procedures and from being on-call in a hospital setting while on probation, a professional competency evaluation, a recordkeeping course completed within six months, and a $5,000 fine. Dr. Nedd takes exception to the ALJ's proposed sanction and argues that the Board should remove the stayed suspension and replace it with a reprimand, shorten the probation to one year and remove the supervision during probation, and remove the professional competency evaluation. The State recommends a one-year suspension of Dr. Nedd's license, a permanent prohibition on all surgical procedures, a professional competency evaluation, a course in medical recordkeeping, two years of probation following the suspension followed by a chart/peer review, and a $25,000 fine.

Dr. Nedd notes several mitigating factors that the Panel has duly considered. Dr. Nedd has 30 years of service to a vulnerable patient population. He is no longer on call or performing

[13] Dr. Nedd was not charged with a standard of care violation for Patient B.

emergency surgeries in a hospital setting, but is performing only endovascular surgeries. Dr. Nedd also has no disciplinary history. Dr. Nedd argued that the charges were based on open vascular procedures for high-risk patients in a hospital setting, while his future endovascular work is elective and carries significantly less risk.

The State argues that Dr. Nedd made significant misrepresentations while under investigation and subjected Patients A and C to significant risks of patient harm. Dr. Nedd's failure to perform a Doppler evaluation of Patient A's foot and the delay in performing bypass surgery increased risks for bad outcomes for the patient. For Patient C, the delay in evaluating Patient C for necrotizing fasciitis and delay in removing an infected graft also increased risks for bad outcomes for the patient.

The Panel has considered Dr. Nedd's mitigating factors of a lack of disciplinary history, rehabilitative potential, and lack of premeditation, as well as the potential harm to patients, and pattern of conduct. COMAR § 10.32.02.09(B)(5), (6). The Panel also has taken into account that Dr. Nedd's violations occurred as part of emergency surgeries in a hospital setting with critically ill patients. Dr. Nedd is now limiting himself to outpatient endovascular work. His limitation to non-emergency and non-"on-call" work provides the Panel with reassurances that there should be decreased risk of patient harm if he continues on that path.

Thus, the Panel believes that with certain limitations on his practice, Dr. Nedd can safely continue his practice without a suspension. Because his deficient actions occurred as part of "on-call" services at a hospital, the Board will prohibit Dr. Nedd from performing on-call emergency procedures for the duration of his probation. The State's concerns regarding Dr. Nedd's practice are well-founded, but this has been Dr. Nedd's only Board action, and the Panel believes that a sanction that involves the prohibition during probation and evaluation and monitoring by the

Maryland Professional Rehabilitation Program will adequately protect the public. The Panel finds that two years is an appropriate amount of time for the probation with these significant limitations. As such, the Panel accepts the ALJ's recommended sanction in part; sustaining the ALJ's recommended two-year probationary period, restriction on emergency procedures or on call procedures during probation, recordkeeping course, and fine. The Panel modifies the ALJ's recommended sanction, in part, removing the stayed suspension and replacing it with a reprimand, and modifying the supervision and competency evaluation and replace it with the requirement that Dr. Nedd to enter into the Maryland Professional Rehabilitation Program during probation.

ORDER

It is, by an affirmative vote of a majority of a quorum of Disciplinary Panel B, hereby

ORDERED that **WILTON NEDD, M.D.**, is **REPRIMANDED**; and it is further

ORDERED that Dr. Nedd is placed on **PROBATION** for a minimum period of **TWO YEARS**.[14] During the probationary period, Dr. Nedd shall comply with the following probationary terms and conditions:

(1) Dr. Nedd is **PROHIBITED** from performing emergency procedures or on-call hospital procedures during probation;

(2) Within **SIX (6) MONTHS**, Dr. Nedd is required to take and successfully complete a course in recordkeeping. The following terms apply:

(a) it is Dr. Nedd's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the course before the course is begun;
(b) Dr. Nedd must provide documentation to the disciplinary panel that Dr. Nedd has successfully completed the course;
(c) the course may not be used to fulfill the continuing medical education credits required for license renewal;
(d) Dr. Nedd is responsible for the cost of the course;

[14] If Dr. Nedd's license expires while he is on probation, the probationary period and any probationary conditions will be tolled. COMAR 10.32.02.05C(3).

(3) Dr. Nedd shall enroll in the Maryland Professional Rehabilitation Program (MPRP) as follows:

(a) Within 5 business days, Dr. Nedd shall contact MPRP to schedule an initial consultation for enrollment;
(b) Within 15 business days, Dr. Nedd shall enter into a Participant Rehabilitation Agreement and Participant Rehabilitation Plan with MPRP;
(c) Dr. Nedd 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) Dr. Nedd 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. Dr. Nedd shall not withdraw his release/consent;
(e) Dr. Nedd 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 Dr. Nedd's current therapists and treatment providers) verbal and written information concerning Dr. Nedd and to ensure that MPRP is authorized to receive the medical records of Dr. Nedd, including, but not limited to, mental health and drug or alcohol evaluation and treatment records. Dr. Nedd shall not withdraw his release/consent;
(f) Dr. Nedd's failure to comply with any of the above terms or conditions including terms or conditions of the Participant Rehabilitation Agreement(s) or Participant Rehabilitation Plan(s) constitutes a violation of this Order;

(4) within **ONE YEAR,** the Respondent shall pay a civil fine of **FIVE THOUSAND DOLLARS**. The Payment shall be by money order or bank certified check made payable to the Maryland Board of Physicians and mailed to P.O. Box 37217, Baltimore, Maryland 21297. The Board will not renew or reinstate the Respondent's license if the Respondent fails to timely pay the fine to the Board; it is further

ORDERED that, after the minimum period of probation imposed by the Order has passed and Dr. Nedd has fully and satisfactorily complied with all terms and conditions for probation, Dr. Nedd may submit a written petition to the disciplinary panel for termination of the probation. Dr. Nedd may be required to appear before the disciplinary panel to discuss his petition for termination. If the disciplinary panel determines that it is safe for Dr. Nedd to terminate the terms of probation, the probation shall be terminated through an order of the disciplinary panel. If the disciplinary

panel determines that it is not safe for the Respondent to terminate the terms of probation, the probation shall be continued through an order of the disciplinary panel for a length of time determined by the disciplinary panel, and the disciplinary panel may impose any additional terms and conditions it deems appropriate; and it is further

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

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

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

ORDERED that, if Dr. Nedd allegedly fails to comply with any term or condition imposed by this Order, Dr. Nedd 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, Dr. Nedd 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 Dr. Nedd has failed to comply with any term or condition imposed by this Order, the disciplinary panel may reprimand Dr. Nedd, place him on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke his 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 Dr. Nedd; and it is further

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

11/30/2021
Date

Signature on File

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

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 14-408(a), Dr. Nedd has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within 30 days from the date of mailing of this Final Decision and Order. The cover letter accompanying this final decision and order indicates the date the decision is mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Dr. Nedd files a petition for judicial review, the Board is a party and should be served with the court's process at the following address:

Maryland State Board of Physicians
Christine A. Farrelly, Executive Director
4201 Patterson Avenue
Baltimore, Maryland 21215

Notice of any petition should also be sent to the Board's counsel at the following address:

David S. Finkler
Assistant Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

Exhibit 1

MARYLAND STATE	*	**BEFORE JOY L. PHILLIPS,**
BOARD OF PHYSICIANS	*	**AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE**
WILTON O. NEDD, M.D.,	*	**OF ADMINISTRATIVE HEARINGS**
RESPONDENT	*	
LICENSE No.: D39795	*	**OAH No.: MDH-MBP2-71-20-25748**

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PROPOSED DECISION

STATEMENT OF THE CASE
ISSUES
SUMMARY OF THE EVIDENCE
STIPULATIONS OF FACT
PROPOSED FINDINGS OF FACT
DISCUSSION
PROPOSED CONCLUSIONS OF LAW
PROPOSED DISPOSITION

STATEMENT OF THE CASE

On July 6, 2020, a disciplinary panel of the Maryland State Board of Physicians (Board) issued charges against Wilton O. Nedd, M.D., (Respondent) alleging violations of the State law governing the practice of medicine, the Maryland Medical Practice Act (Act). Md. Code Ann., Health Occ. §§ 14-101 through 14-508, and 14-601 through 14-607 (2014 & Supp. 2020). Specifically, the Respondent is charged with violating two provisions in section 14-404 of the Act. Health Occ. §§ 14-404(a)(22) (standard of care) and (40) (medical recordkeeping) (Supp. 2020); Code of Maryland Regulations (COMAR) 10.32.02.03E(3)(d). The disciplinary panel to which the complaint was assigned forwarded the charges to the Office of the Attorney General for prosecution, and another disciplinary panel delegated the matter to the Office of Administrative Hearings (OAH) to issue proposed findings of fact, proposed conclusions of law, and a proposed disposition. COMAR 10.32.02.03E(5); COMAR 10.32.02.04B(1).

I held a hearing on April 6, 7, 8, and 16, 2021 from the OAH via a video conferencing platform. Health Occ. § 14-405(a) (Supp. 2020); COMAR 10.32.02.04. Katherine Vehar-Kenyon, Assistant Attorney General and Administrative Prosecutor, represented the State of Maryland (State). Bradford J. Roegge, Esquire, represented the Respondent, who was present.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules for Hearings before the Board , and the Rules of Procedure of the OAH. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2014 & Supp. 2020); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

1. Did the Respondent violate the cited provisions of the Act? If so,
2. What sanctions are appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following exhibits into evidence on behalf of the State[1]:

St. Ex. 1 - Maryland Board of Physicians Mandated 10-Day Report from [redacted], received June 25, 2018
St. Ex. 2 - [redacted] Quality Assurance/Risk Management (QA/RM) file, subpoena duces tecum dated July 6, 2018
St. Ex. 3 - Not admitted
St. Ex. 4 - Transcript of interview with [redacted], M.D., November 7, 2018
St. Ex. 5 - Respondent's Summary of Care re: Patient A, undated
St. Ex. 6 - Subpoena for [redacted] Medical Records[2] re: Patient A, admission May 26, 2014
St. Ex. 7 - Respondent's Summary of Care re: Patient B, undated
St. Ex. 8 - Subpoena for [redacted] Medical Records[3] re: Patient B, admission January 4, 2017
St. Ex. 9 - Respondent's Summary of Care re: Patient C, undated

[1] Prior to the hearing, the Respondent moved to exclude four exhibits to be offered by the State. I heard arguments on the motion on March 23, 2021. On the record, I denied the motion to exclude evidence of the Respondent's lack of board certification and held the other motions under advisement. At the hearing on the merits, the Respondent withdrew the motion to exclude evidence regarding prior acts of malpractice; I denied the motion to exclude State Exhibit 2, the Quality Assurance/Risk Management (QA/RM) file from [redacted]; and I granted the motion to exclude State Exhibit 3, the QA/RM file from [redacted].

[2] Records are on disc accompanying the file.

[3] Records are on disc accompanying the file.

Subpoena for [redacted] Medical Records[4] re: Patient C, admission August 12, 2017
Curriculum Vitae of [redacted], M.D.
12 - Peer Review Report of [redacted], M.D.
13 - Respondent's Supplemental Board Response, received March 3, 2020
Ex. 14 - Board's Charging Document, July 6, 2020

I admitted the following exhibits into evidence on behalf of the Respondent:

Resp. Ex. 1 - Maryland Board of Physicians Mandated 10-Day Report from [redacted], received June 25, 2018
Resp. Ex. 2 - [redacted] QA/RM file, subpoena duces tecum dated July 6, 2018
Resp. Ex. 3 - [redacted] Medical Records re: Patient A, admission May 26, 2014
Resp. Ex. 4 - Respondent's Summary of Care re: Patient A, undated
Resp. Ex. 5 - [redacted] Medical Records re: Patient B, admission January 4, 2017
Resp. Ex. 6 - Respondent's Summary of Care re: Patient B, undated
Resp. Ex. 7 - [redacted] Medical Records re: Patient C, admission August 12, 2017
Resp. Ex. 8 - [redacted] Medical Records re: Patient A, admission June 5, 2014
Resp. Ex. 9 - Respondent's Supplemental Board Response, received March 3, 2020
Resp. Ex. 10 - Curriculum Vitae of the Respondent
Resp. Ex. 11 - Report of [redacted], M.D., March 12, 2021
Resp. Ex. 12 - Curriculum Vitae of [redacted], M.D.
Resp. Ex. 13 - Arora, S., M.D., *et al.*, *Common femoral artery ligation and local debridement: A safe treatment for infected femoral artery pseudoaneurysms*, J. Vascular Surg. 33:990-93 (2001)
Resp. Ex. 14[5] - Medical Illustrations - Leg Arteries, undated

Testimony

The Board presented the testimony of [redacted], M.D., who was admitted as an expert in vascular surgery; treatment of complications from cardiac catheterizations; treatment of complications from carotid surgery; quality patient management in operating arenas, specifically hospitals; informed surgical consent in vascular surgery; appropriate and complete medical documentation in vascular surgery; care and treatment of infected dialysis grafts; the diagnosis of sepsis; and the treatment and management of patients with sepsis.

[4] Records are on thumb drive accompanying the file.
[5] Volumes 1 through 4 of the Respondent's exhibits contain all of the foregoing exhibits. For hearing, some of those exhibits were placed in the Respondent's Exhibit Extract Binder for convenience. This exhibit appeared only in the Exhibit Extract Binder, marked as Exhibit 8. I have renumbered it Exhibit 14 and moved it from the Exhibit Extract Binder to the end of Volume 4. My references to exhibit numbers refer to Volumes 1-4, not to the Exhibit Extract Binder.

The Respondent testified on his own behalf, and presented the testimony of [redacted], M.D., who was admitted as an expert in vascular surgery and the standard of care.

STIPULATIONS OF FACT[6]

1. At all times relevant to the Charges,[7] the Respondent was, and is, licensed to practice medicine in the State of Maryland.

2. The Respondent was originally licensed to practice medicine in Maryland on March 28, 1990, under license number D39795.

3. The Respondent's license is current through September 30, 2021.

4. The Respondent is not board-certified in vascular surgery or any other field of medicine.

5. At the time of the events giving rise to the Charges, the Respondent had admitting and surgical privileges at [redacted] in Prince George's County, Maryland.

6. On or about June 25, 2018, the Board received a Mandated 10-Day Report from [redacted] stating that on June 6, 2018, the Respondent, after being placed on a Focused Professional Practice Evaluation (FPPE) that stemmed from an investigation initiated after a medical malpractice claim, voluntarily resigned and surrendered his privileges prior to completion of the FPPE process.[8]

7. The Board subpoenaed the Respondent's Quality Assurance/Risk Management (QA/RM) file from [redacted]. The Board received the Respondent's QA/RM file from [redacted] on or around August 15, 2018, and it is authentic.[9]

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[6] I have reworded some of the stipulations where needed for consistency with the remainder of the decision or for grammatical purposes.
[7] The Charges are identified below.
[8] St. Ex. 1.
[9] St. Ex. 2.

8. The Board subpoenaed the Respondent's QA/RM file from [redacted]. The Board received the Respondent's QA/RM file from [redacted] on or around September 13, 2018, and it is authentic.[10]

9. On November 7, 2018, Board compliance analysts interviewed [redacted], M.D. The interview transcript fairly and accurately depicts the under-oath interview.[11]

10. Based on the Mandated 10-Day Report from [redacted], the Board initiated an investigation. As part of the investigation, the Board subpoenaed patient charts and requested a peer review of three patient charts.

11. [redacted] transmitted the medical records of Patients A, B, and C.[12]

12. The medical records for Patient A are State Exhibit 6 and they are authentic.

13. The medical records for Patient B are State Exhibit 8 and they are authentic.

14. The medical records for Patient C are State Exhibit 10 and they are authentic.

15. On or about April 26, 2019, the Board requested, and the Respondent provided, Summaries of Care for the three patients whose charts were peer reviewed. The Board received the Respondent's Summaries of Care on or about May 5, 2019.

16. The Respondent's Summary of Care for Patient A is State Exhibit 5, and it is authentic.

17. The Respondent's Summary of Care for Patient B is State Exhibit 7, and it is authentic.

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[10] St. Ex. 3. This exhibit was not admitted.
[11] St. Ex. 4.
[12] Patient names and initials appear in the exhibits and their charts are numbered in some exhibits. In this Proposed Decision, Patient A is [redacted] (Chart #1); Patient B is [redacted] (Chart #2); Patient C is [redacted] (Chart #3).

18. The Respondent's Summary of Care for Patient C is State Exhibit 9, and it is authentic.

19. The Board referred the investigatory file to a peer review entity.

20. On February 10, 2020, the peer review reports were provided to the Respondent and the Board requested that the Respondent provide a Supplemental Board Response to the peer review reports.

21. On March 10, 2020, the Board received the Respondent's Supplemental Board Response.[13]

PROPOSED FINDINGS OF FACT

I find the following facts by a preponderance of the evidence:

General Information on the Respondent

22. The Respondent has been licensed to practice medicine in Maryland since 1990 and in Washington, D.C. since 1982.

23. The Respondent had admitting privileges at [redacted] for approximately twenty-five years, ending July 26, 2017.

24. The Respondent was under an FPPE at [redacted] from 2012 to 2015.

25. In his Supplemental Board Response, the Respondent wrote that the FPPE at [redacted] was "the first of its kind for me in 30 years of practice."[14]

26. The FPPE at [redacted], which had been extended beyond the initial six-month period, was not yet completed when the Respondent resigned. The Medical Executive Committee had met and made numerous recommendations, however. The Respondent resigned before [redacted] made a final decision.[15]

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[13] St. Ex. 13.
[14] St. Ex. 13, p. 2.
[15] State Ex. 4, pp. WN 00452-53.

27. The Respondent currently maintains admitting privileges at [redacted] in Washington, D.C., and works in endovascular facilities two to three days per week.

28. The Respondent has not previously been disciplined by the Board.

The Three Patients at Issue

Patient A

29. Patient A was seventy-two years old in 2014. Patient A's medical history included renal insufficiency, coronary artery disease, hypertension, hyperlipidemia, and thyroid disease.

30. Patient A was admitted to the [redacted] emergency department on May 26, 2014, for an acute myocardial infarction[16] with near total occlusion[17] of the right coronary artery. On May 27, 2014, she underwent a right transfemoral cardiac catheterization[18] to implant five right coronary stents in the blood vessels. To obtain hemostasis,[19] a femoral artery Angio-Seal device[20] was utilized. The Respondent was not the surgeon. On May 29, 2014, Patient A was discharged from [redacted].

31. On June 2, 2014, Patient A was readmitted to the [redacted] emergency department at 2:43 p.m. with signs of sepsis[21] due to an infected right groin hematoma.[22] She had been experiencing nausea, vomiting, diarrhea, and a fever with chills. The Respondent was called for a consult and met with Patient A at 9:00 p.m.[23]

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[16] Myocardial infarction is the injury or death of heart tissue as a result of inadequate blood supply. Definitions of medical terms come from the Charges, with agreement by the Respondent, or from the State's definitions used at the hearing.
[17] Occlusion is an obstruction of an anatomical passage.
[18] Transfemoral cardiac catheterization is a procedure whereby a long, thin tube, also known as a catheter, is inserted into the femoral artery of the leg in order to gain access to the vascular system and ultimately, the heart.
[19] Hemostasis is a process that leads to the cessation of bleeding from a blood vessel.
[20] An Angio-Seal is a vascular closure device used to secure a puncture site.
[21] Sepsis is a potentially life-threatening condition caused by an imbalance of chemicals released by the body to fight infection.
[22] Hematoma is a collection of blood outside of a blood vessel.
[23] Resp. Ex. 3, pp. WN 00820-22.

32. The Respondent documented that Patient A was admitted "in septic shock."[24] He did not document that he conducted a full vascular examination of Patient A. He determined she had an infected hematoma that had developed where the Angi-Seal device had been inserted after the catherization.

33. The Respondent ordered IV fluids and continued antibiotics to clear the infection. A non-contrast pelvic computerized tomography (CT) scan[25] was consistent with a groin hematoma or abscess but did not rule out other etiologies.[26]

34. On June 3, 2014, the Respondent obtained surgical consent from Patient A for "exploration of right groin with incision and drainage of abscess."[27] Patient A signed the consent form at 00:30 hours. The Respondent signed it at 5:05 p.m. The consent form did not include the possibility of a bypass, despite the likelihood a bypass would be needed.[28]

35. On June 3, 2014, beginning at about 5:30 p.m., the Respondent performed an exploration of Patient A's right groin, a thrombectomy[29] of the right superficial femoral artery[30] with ligation,[31] and partial resection of the common femoral artery after finding a very infected hematoma caused by the Angio-Seal. He ligated a segment of friable[32] right common artery.

36. The Respondent did not document the appearance of Patient A's right foot or conduct an intraoperative Doppler evaluation[33] at the conclusion of the ligation.[34]

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[24] Resp. Ex. 3, p. WN 00965-67.
[25] Resp. Ex. 3, p. WN 001181.
[26] Abscess is a localized collection of pus in tissues, organs, or confined spaces usually because of an infection.
[27] St. Ex. 6, p. WN 00942.
[28] Resp. Ex. 3, p. WN 00869.
[29] Thrombectomy is a type of surgery to remove a blood clot inside an artery or vein to allow blood to flow.
[30] The right superficial femoral artery is a continuation of the common femoral artery and is the main artery of the lower limb.
[31] Ligation is the act of tying a blood vessel with a piece of thread or wire that prevents blood flow to areas supplied by the vessel.
[32] Friable was defined by the parties as "Swiss cheese." T. p. 35.
[33] Doppler signals are used to measure the amount of blood flow in a given area of the body.
[34] Resp. Ex. 3, p. WN00966.

37. On the morning of June 4, 2014, the attending physician, Dr. [redacted], observed that Patient A's foot was "ice cold, pale . . . without palpable pulses with no measurable capillary refill."[35]

38. The Respondent examined Patient A on June 4, 2014, at about 8:34 a.m. and found her right foot responded to pinprick, leading him to conclude her limb was still viable and there was no emergency. The Respondent's visit is documented when he wrote, "Earlier when seen," referencing Patient A.[36] "Earlier" refers to the time he ordered the CT scan.[37]

39. On June 4, 2014, prior to 5:16 p.m., when he dictated his note, the Respondent noted that when he examined Patient A, he found her right foot to be cold. He noted that "[b]ecause of sedation I am unable to elicit response though she does withdrawn (sic) to pin prink (sic) on the right foot."[38] Based on this response, the Respondent determined her foot was still viable.

40. The Respondent had requested a CT Angiogram (CTA) be performed on June 4, 2014, to determine a potential site to revascularize the ischemic[39] limb. Radiology cancelled the CTA due to Patient A's elevated creatinine, but the Respondent was not informed of the cancellation.

41. The Respondent ordered a Magnetic Resonance Angiogram (MRA)[40] without contrast. That was performed at approximately 11:42 a.m. on June 4, 2014. The radiologist, [redacted], D.O., performed the MRA of Patient A's abdomen, pelvis, and legs. The MRA revealed the right external iliac flow was decreased relative to the left leg. The radiologist documented occlusion of the right distal external iliac just prior to the common femoral artery.

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[35] Resp. Ex. 3, p. WN 00911.
[36] Resp. Ex. 3, pp. WN 00913-14.
[37] Resp. Ex. 3, p. WN 001081.
[38] Resp. Ex. 3, p. WN 00913.
[39] Ischemia is lack of blood flow and oxygen. T. p. 14
[40] MRA is a test in which radio waves, a magnetic field, and a computer are used to image blood vessels.

In addition, the radiologist noted blood flow in the right profunda, while also writing that no flow was identified in the popliteal or runoff arteries.[41]

42. At about 4:00 p.m. on that day, the Respondent reviewed the MRA results with the radiologist.

43. At 4:55 p.m. on June 4, 2014, the Respondent obtained a signed consent to perform "exploration of right popliteal artery with intraoperative angiogram and possible bypass."[42]

44. That evening, the Respondent performed surgery on Patient A in which he inserted a right ilio-popliteal artery bypass graft. Patient A entered the operating room at 19:11 p.m. The surgery was conducted between 20:09 and 23:19 p.m.[43] Doppler signals were good at the conclusion of the procedure.

45. In his dictated notes from June 4, 2014, the Respondent accounted for not getting Patient A into surgery until 7:00 p.m. that evening to other emergencies ongoing in the operating room. He wrote: "The wait to get this patient on the operating room table lasted about ten hours after the intended procedure was declared. This was due to operating room emergencies."[44]

46. In his Summary of Care submitted to the Board, the Respondent accounted for the delay to get into surgery to the cancellation of the CTA and the wait for the MRA results.[45]

47. In the [redacted] Medical Executive Committee's summary of questions and answers by the Respondent regarding his care in Patient A's case, it was revealed that the Respondent had another surgery during that day. He could not recall whether it was an elective, urgent, or emergent operation.[46]

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[41] Resp. Ex. 3, pp. WN 00848 and 01183-84.
[42] Resp. Ex. 3, p. WN 00945.
[43] Resp. Ex. 3, p. WN 00961.
[44] Resp. Ex. 3, p. WN 00972.
[45] St. Ex. 5, pp. WN 00455-56.
[46] St. Ex. 2, p. WN 00031.

48. On June 5, 2014, prior to 1:42 p.m., when he dictated his note, the Respondent found that Patient A's right leg was "warm up to a point about 4 inches superior to the ankle. There is at this point a strongly Dopplerable pulse along the course of the posterior tibial artery. However, beyond that point there [was] no palpable or Dopplerable pulse. The foot is cold. She is moving her foot and wiggling her toes."[47]

49. The Respondent recommended that Patient A return to surgery to try to increase perfusion (blood flow) to the right foot.

50. Patient A's family requested that she be transferred to another hospital. She was transferred to [redacted], as requested.[48]

51. On June 14, 2014, Patient A underwent an amputation of her right lower leg. She suffered multi-organ failure due to septic emboli in her liver, spleen, aorta, and kidneys.

52. On July 8, 2014, Patient A died of cardiac arrest.[49]

Patient B

53. Patient B was eighty-four years old in 2017. He was admitted to the [redacted] emergency department on January 4, 2017, following a syncopal episode.[50]

54. On January 10, 2017, the Respondent performed a right carotid endarterectomy[51] with patch angioplasty on Patient B.[52] Shortly after the surgery, Patient B developed a neck hematoma with stridor.[53]

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[47] Resp. Ex. 3, p. WN 00917.
[48] Resp. Ex. 3, p. WN 00833.
[49] Resp. Ex. 8, p. WHC 000008.
[50] Syncope is a temporary loss of consciousness.
[51] Carotid Endarterectomy is a procedure to open the carotid artery and remove any blockage found therein.
[52] Resp. Ex. 5, pp. WN 02428-30.
[53] Stridor is an abnormal, high-pitched sound produced by turbulent airflow through a partially obstructed airway.

55. On January 11, 2017, the Respondent performed a surgery to evacuate Patient B's neck hematoma.[54] He did not place a drain during the surgery; however, a drain is not required under the standard of care.

56. Patient B recovered from the surgery.

57. In his Summary of Care submitted to the Board, the Respondent wrote: "Usually, I do NOT[55] place a drain after my procedures. [Patient B] was taken back to the [operating room] for exploration where no active bleeding vessel was found, instead he was oozing from the raw surfaces. Once explored, I placed a drain and returned back to the ICU."[56]

58. In fact, he did not place a drain during Patient B's surgery. The Respondent intended to write "placed a dressing" not "placed a drain."

59. Medical records for Patient B do not mention a drain at all. The only mention of a drain is in the Respondent's Summary of Care written in response to the Board's inquiry.

Patient C

60. Patient C was seventy-four years old in 2017. She had a complex medical history, including diabetes mellitus, obesity, hyperlipidemia, end stage renal failure, coronary artery disease, seizure disorder, severe peripheral vascular disease, and bilateral above-the-knee amputations.

61. On August 2, 2017, the Respondent performed an elective placement of a loop dialysis graft (also referred to as an AV[57] graft) on Patient C's right thigh. She was discharged following the surgery.

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[54] Resp. Ex. 5, pp. WN 02421-22.
[55] This was capitalized in the Respondent's Summary of Care.
[56] St. Ex. 7.
[57] AV graft is an arteriovenous graft. T. p. 211.

62. On August 12, 2017, Patient C was readmitted to [redacted] with vomiting, dark stools, and hypotension during dialysis.[58] Posterior thigh wounds and broken blisters were noted by wound care nurses on August 13, 16 and 18, 2017.[59] She was discharged on August 18, 2017.

63. On August 21, 2017, at 11:33 a.m., Patient C was admitted to the [redacted] emergency department with an infected graft in her right groin.[60] The attending physician ordered a CT scan to evaluate for necrotizing infection. That physician talked to the Respondent on the telephone twice about Patient C. Based on the attending's observations and the results of a CT scan, the Respondent concluded Patient C did not have necrotizing fasciitis.[61] He planned to see Patient C that evening or the next morning, ultimately waiting until the next day.[62]

64. On August 21, 2017, Patient C had an INR[63] of 3.4.[64]

65. The Respondent examined Patient C on August 22, 2017, in the morning, as documented by [redacted], M.D.[65]

66. The Respondent dictated his consultation notes at approximately 8:05 p.m. on August 22, 2017. He noted Patient C's white blood cell count was 25,600, up from 23,000 when she was admitted, and indicated she was bacteremic,[66] not septic. He noted she needed to have the infected graft removed. Patient C's INR had increased to 4.29.[67]

67. The Respondent planned to delay surgery until the INR was down to 2 or below.

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[58] Records beginning at Resp. Ex. 7, p. WN 04962.
[59] Resp. Ex. 7, pp. WN 05094 (note), 05028 (photo), and 05000 (note).
[60] Records for this admission begin at Resp. Ex. 7, p. WN 05624. Emergency department note begins at WN 05664.
[61] The parties described necrotizing fasciitis as an infection the destroys the body's soft tissue. T. p. 17.
[62] Resp. Ex. 7, p. WN 05667.
[63] INR is International Normalized Ratio, referring to the ability of blood to clot. T. p. 212. The higher the number, the harder it is to clot. Patient C took Coumadin, a blood thinner, which accounted for the high INR level.
[64] Resp. Ex. 7, p. WN 05702.
[65] Resp. Ex. 7, p. WN 05733.
[66] Bacteremia is a localized infection. T. 31.
[67] Resp. Ex. 7, p. WN 05704.

68. On August 23, 2017, a nurse treated Patient C's right posterior thigh wound with saline and documented the width and length of the wound.[68]

69. On August 23, 2017, Patient C received three units of packed red blood cells and two units of fresh frozen plasma with dialysis.[69]

70. On August 23, 2017, at 8:51 p.m., the Respondent documented that Patient C had an INR of 1.83 and scheduled the graft removal operation for the following day.[70] Her hemoglobin was at 6.5 and the Respondent believed it was too low to do surgery. He ordered transfusions in dialysis the following day before surgery.

71. On August 24, 2017, between 5:26 p.m. and 7:15 p.m., the Respondent performed graft removal and extensive radical wound debridement of Patient C.[71] Wound debridement included a large wound on the posterior of the right thigh. Patient C's INR level was 1.58 prior to surgery.[72]

72. Regarding that thigh wound, the Respondent wrote in his operative notes that there was a large necrotic area on the posterior thigh. He wrote, "When the patient was initially admitted, she never did allow for the stump to be touched, and therefore, this wound was "overlooked by the team."[73] However, the medical staff at [redacted] had treated that wound when Patient C was hospitalized between August 12 and 18, 2017 and again on August 23, 2017, the day before her surgery.

73. On August 26, 2017, Patient C suffered cardiac arrest.

74. Patient C died on August 27, 2017.

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[68] Resp. Ex. 7, p. WN 06252.
[69] Resp. Ex. 7, pp. WN 05722, 05727-28.
[70] Resp. Ex. 7, p. WN 05740.
[71] Operative note at Resp. Ex. 7, pp. WN 05818 and 05847-49.
[72] Resp. Ex. 7, p. WN 06104.
[73] Resp. Ex. 7, p. WN 05848.

DISCUSSION

Burden of Proof and Legal Framework

When not otherwise provided by statute or regulation, the standard of proof in a contested case hearing before the OAH is a preponderance of the evidence, and the burden of proof rests on the party making an assertion or a claim. Md. Code Ann., State Gov't § 10-217 (2014); COMAR 28.02.01.21K. To prove an assertion or a claim by a preponderance of the evidence means to show that it is "more likely so than not so" when all the evidence is considered. *Coleman v. Anne Arundel Cty. Police Dep't*, 369 Md. 108, 125 n.16 (2002). In this case, the Board bears the burden to show the Respondent violated the standard of care or failed to keep adequate medical records by a preponderance of the evidence. COMAR 28.02.01.21K(1)-(2)(a).

The grounds for reprimand or probation of a licensee, or suspension or revocation of a license under the Act include the following:

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

Health Occ. § 14-404(a) (Supp. 2020).

The Charges

As to Patient A, the Board charged the Respondent with failing to meet the standard of care, in violation of Health Occupations Article section 14-404(a)(22), by:

a) Failing to perform an evaluation of pedal Doppler signals to ensure limb viability at the conclusion of the femoral artery ligation procedure on June 3, 2014.

b) Failing to perform an assessment of the appearance of the right foot for viability at the conclusion of the femoral artery ligation procedure on June 3, 2014.
c) Failing to timely treat ischemia of Patient A's foot following the femoral artery ligation procedure on June 3, 2014.
d) Failing to obtain proper informed surgical consent from Patient A prior to the surgery on June 3, 2014.

(St. Ex. 14, p. 7).

As to Patient A, the Board charged the Respondent with failing to keep adequate medical records, in violation of Health Occupations Article section 14-404(a)(40), by:

a) Failing to document vascular examination upon Patient A's admission to the Hospital on June 2, 2014.
b) Failing to document complete surgical consent of the anticipated procedure on June 3, 2014.
c) Failing to document the appearance of Patient A's right foot at the conclusion of the femoral artery ligation procedure on June 3, 2014.
d) Failing to document a Doppler evaluation at the conclusion of the femoral artery ligation procedure on June 3, 2014.
e) Failing to document patient evaluation during the morning of June 4, 2014, or after discussing Patient A's condition with the attending physician on June 4, 2014.

(St. Ex. 14, pp. 7-8).

As to Patient B, the Board charged the Respondent with failing to keep adequate medical records, in violation of Health Occupations Article section 14-404(a)(40), by:

a) Failing to document the intraoperative placement of a drain, the amount of post-operative drainage, or the removal of a drain.
b) Failing to accurately document Patient B's condition.

(St. Ex. 14, p. 9).

As to Patient C, the Board charged the Respondent with failing to meet the appropriate standard of care, in violation of Health Occupations Article section 14-404(a)(22), by:

a) Failing to actively monitor a critically ill patient with known risk factors for developing gangrene.
b) Failing to consult the daily chart wound assessment and treatment notes prepared by the Hospital staff.

(St. Ex. 14, p. 11).

As to Patient C, the Board charged the Respondent with failing to keep adequate medical records, in violation of Health Occupations Article section 14-404(a)(40), by:

a) Documenting a lack of knowledge of Patient C's condition, which in fact had been previously established, leading to inaccurate or contradictory medical records.

(St. Ex. 14, p. 11).

Arguments of the Parties

The State argued that the Respondent has a history of delaying surgeries and failing to adequately document patients' medical charts. It asserted that the Respondent cannot hide behind the complex medical diagnoses of his patients. It called his actions "unconscionable" and accused the Respondent of putting his career in front of the truth. In response to the Respondent's argument that the patients were not harmed as a result of the Respondent's actions, the State reminded me that causation is not an issue in whether he breached the standard of care, but that the risk of harm only impacts sanctions. Because of the severity of delays or failures in the cases of the three patients at issue, the State is seeking a variety of sanctions, including: suspension of the Respondent's medical license for one year; permanent prohibition on all surgical procedures; professional competency evaluation; course in medical record keeping within six months; two years' probation once he is deemed competent to practice medicine, with chart/peer review; and $25,000.00 fine as a deterrent and because he was contemptuous of the process.

The Respondent argued that while his documentation may have been lacking in some areas, his medical care of the three patients met the standard of care and nothing he did caused harm to them. He emphasized that Patient A and Patient C were brought into the emergency department and had numerous comorbidities which rendered them vulnerable and very difficult to treat. He said the State is grossly overreaching in its requested sanctions and that far milder sanctions, if any, are appropriate given the evidence. He urged me to stay focused on what a

reasonable surgeon would do under the same circumstances. He suggested the following sanctions, depending on my findings on the evidence: reprimand; prohibition from performing emergent procedures in a hospital setting; medical documentation course; probation for no more than one year; and no fine.

Expert Witnesses

On the issue of expert testimony, the Court of Appeals has held: "The premises of fact must disclose that the expert is sufficiently familiar with the subject matter under investigation to elevate his opinion above the realm of conjecture and speculation, for no matter how highly qualified the expert may be in his field, his opinion has no probative force unless a sufficient factual basis to support a rational conclusion is shown." *Bohnert v. State*, 312 Md. 266, 274 (1988) (social worker's expert testimony that child under age of fourteen was a victim of sexual abuse was inadequately supported and was inadmissible in prosecution for second-degree sexual offense) (citing *State, Use of Stickley v. Critzer*, 230 Md. 286, 290 (1962)). The Maryland Rules provide: "Expert testimony may be admitted . . . if the court determines that the testimony will assist the trier of fact to . . . determine a fact in issue. In making that determination, the court shall determine . . . whether a sufficient factual basis exists to support the expert testimony." Md. Rule 5-702.

There was no objection by either party regarding each expert's qualifications and I accepted both experts in the respective fields for which they were offered. Dr. [redacted] and Dr. [redacted] have decades of experience and vast training. Each witness provided me with valuable information and insights.

An expert opinion may nevertheless be tested for bias. As noted by the Court of Appeals of Maryland in *Wrobleski v. de Lara*, 353 Md. 509 (1999):

> The professional expert witness advocating the position of one side or the other has become a fact of life in the litigation process. Practicing lawyers can quickly

> and easily locate an expert witness to advocate nearly anything they desire. In each part of the country, if you need an expert medical witness to state that plaintiff suffered a whiplash injury, call expert X; if you need a medical expert to dispute that fact, call expert Y. The use of the expert witness has become so prevalent that certain expert witnesses now derive a significant portion of their total income from litigated matters.

Id. at 515-516 (internal citations omitted). I heard nothing during the hearing to suggest either expert was biased in his views, either in favor of the Board or against the Respondent or vice versa. Dr. [redacted] has testified for the Respondent's law firm previously, but he had no personal connection with the Respondent. The experts had no apparent interest in the outcome of the hearing and had no role in determining whether the Respondent will be sanctioned. They were paid for their work in this case and rightly so. Contrary to the arguments of counsel, that does not render them "professional witnesses" such that either is not worthy of belief. There was no evidence either witness derives a significant amount of his income by testifying as an expert in matters such as the instant case.

I note that both experts, as well as the Respondent, are more familiar than I am with the technical, scientific, and medical terms used. I deferred to the experts on some of the issues before me and evaluated the expert opinions of each expert as to whether the Respondent failed to meet the standard of care for quality medical care or failed to keep adequate medical records. Each expert offered opinions as to each of these areas, and I gave those opinions the weight I determined they deserved but did not adopt either of the experts' opinions as my own. I have summarized their opinions below.

In analyzing the evidence, I have assessed the Respondent's credibility. While I do not cast aspersions on his career as a vascular surgeon, a number of his answers or responses to the Board called his credibility into question. For example, he wrote to the Board that he had never been involved in an FPPE when, in fact, the FPPE at [redacted] lasted three years, from 2012 to 2015. He struggled to answer a question regarding how he could forget being under investigation for so long

and how he could fail to report that to the Board. I have noted other examples of inconsistent or confusing answers below.[74]

Patient A

Standard of Care

The Charges alleged the Respondent failed to meet the standard of care when he did not perform a Doppler evaluation or an assessment of the right foot for viability at the conclusion of the ligation procedure on June 3, 2014. The Charges also allege the Respondent did not timely treat ischemia of Patient A's foot after the June 3, 2014 surgery and that he did not obtain proper informed surgical consent prior to the June 3, 2014 surgery because he did not list bypass as a possible procedure that would be performed.

Regarding the Doppler signal scan to determine whether Patient A had any pulse signals after the ligation procedure performed on June 3, 2014, Dr. [redacted] testified that using a Doppler is required by the standard of care, as it informs the surgeon whether there is any blood flow to the extremity following a ligation. Dr. [redacted] countered that some studies support the conclusion that performing the Doppler is not required by the standard of care and can even risk the false conclusion that the absence of pulses means there is no blood flow when actually the patient is still simply too cold for pulses to register. Accordingly, Dr. [redacted] said that waiting a few hours for the patient to warm up is advisable. In support of his opinion, he attached an article to his report. Arora, S., M.D., *et al.*, *Common femoral artery ligation and local debridement: A safe treatment for infected femoral artery pseudoaneurysms*, J. Vascular Surg. 33:990-93 (2001). (Resp. Ex. 13).

[74] The State pointed out that the Respondent did not mention [redacted] in his resume, even though he was employed there for fifteen years and resigned during the FPPE, which resignation triggered the Mandatory 10-Day Review. Resp. Ex. 10. I attribute this to sloppiness, not to an intent to deceive. Thus, it did not impact my credibility findings.

In arguing their positions, the parties quoted from the article. I will set forth the quotes they used, as well as other sections from the article, for context:

> CFA ligation and local debridement are safe treatment modalities for IFAP, if there is an intraoperative Doppler signal over a pedal artery during test occlusion of the distal EIA/CFA. (p. 990).

> We report our experience with six cases of IFAP due to intravenous drug abuse. We performed CFA ligation with or without ligation of the superficial femoral artery (SFA) and profunda femoris artery along with local debridement and drainage as the sole procedure, without any form of formal revascularization if a Doppler signal was obtained over a pedal artery on test clamping of the distal external iliac artery (EIA) and CFA. (p. 990).

> A Doppler signal over a pedal artery was present in all six patients after ligation of the CFA. (p. 991).

> The diagnosis was confirmed with duplex ultrasound scan in all six patients. We found duplex ultrasound scan to be extremely helpful and accurate in confirming our clinical diagnosis, in contrast to the findings of Reddy et al[75] and Sandler et al.[76] They did not find ultrasound scan useful, but their studies were done more than 10 years ago and refinements in technology might explain the superior accuracy of duplex ultrasound scan today. (p. 992).

The article suggests that Doppler scans are routinely done after ligation to determine the existence of pedal signals and that they are a reliable indicator of whether revascularization must be performed immediately. Immediate arterial revascularization, which, in drug users, must often be completed using a synthetic conduit, may result in complications and loss of life or limb. The Respondent cited the article to support his decision not to perform an immediate revascularization on Patient A and to justify not performing a Doppler scan.

The State used the article to support its argument that the Respondent should have performed a Doppler scan intraoperatively. I agree that the article supports the State's position that a Doppler scan should have been performed. Dr. [redacted] testified that the standard of

[75] Footnote 7 in the article referenced: Reddy D.J., *et al.*, *Infected femoral artery false aneurysms in drug addicts: evolution of selective vascular reconstruction.* J. Vascular Surg. 3:718-724 (1986).
[76] Footnote 10 in the article referenced: Sandler M.A., *et al.*, *Inflammatory lesions of the groin: ultrasonic evaluation.* Radiology 151:747-50 (1984).

care requires that a Doppler be performed to assess blood flow after ligation surgery, even if the signals are weak. He refuted the Respondent's testimony that there was adequate back flow and thus, no Doppler evaluation was needed. Dr. [redacted]'s opinion, which may be sound and accepted in medical circles, that signals heard in a Doppler scan may be useful, but the lack of pulses does not necessarily mean there is no blood flow, was not corroborated by medical literature submitted during the hearing. As revealed in the above quote, the one study cited by the article was over ten years old and the Doppler scan had improved in the intervening years.

There is a discrepancy in the record regarding whether Doppler scans were done after Patient A's surgeries. Regarding the first surgery, on June 3, 2014, there is no Doppler scan documented in the medical evidence and Dr. [redacted] took issue with the Respondent's failure to use one. At the hearing, the Respondent testified that he did not use a Doppler scan because Patient A's body would have been too cold for any signal to register.[77] Yet in his answers to the [redacted] Medical Executive Committee in May 2017, the Respondent said that there WAS a Doppler signal in the foot after the first surgery.[78] Because of this and his assessment that her foot had motor function, he determined it was viable and thus, he did not need to do a bypass immediately. He did not dispute that his surgical report fails to include that he conducted a foot examination after the June 3, 2014 surgery, as charged.

The Respondent testified that he had many IV-using patients over the years who had tolerated that approach without a problem; only one of over forty patients died when he performed separate surgeries rather than doing the bypass at the same time as the ligation. He knew Patient A had a patent[79] vessel, he testified, and knew her foot would not become ischemic.

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[77] T. p. 478.
[78] St. Ex. 2, p. WN 00031.
[79] Patent is open. T. 320.

Because patients are so cold during surgery, he generally waited four to six hours after a patient warmed up from surgery to check for pedal pulses.

Regarding the second surgery, on June 4, 2014, Dr. [redacted] testified there was a Doppler scan done and the Respondent's testimony supports this. However, the Medical Executive Committee determined there was no Doppler scan done in the second surgery either.[80] This discrepancy was not explained during the hearing. The Respondent said he used a Doppler scan in the second surgery because the bypass he performed would have increased Patient A's blood flow and therefore, signals would be audible despite her cold temperature.[81]

Dr. [redacted] testified that the Respondent failed to respond timely to Patient A's ischemia that developed after her ligation procedure. Dr. [redacted] noted Patient A's cold, right foot at about 10:31 a.m. the next morning and the Respondent was notified.[82] The Respondent explained that Patient A's condition prevented him from doing a bypass immediately after the ligation procedure on June 3, 2014. He did not yet have proper imaging for the operation. She was in septic shock, and she had coronary artery disease. He said the anesthesiologist reminded him of her drop in blood pressure. The Respondent said that on June 4, 2014, Patient A responded to pinprick and therefore, he knew her foot was viable. Thus, getting her to surgery was not an emergency, he asserted. The surgery was not performed until that evening, between 8 and 10 p.m.

Dr. [redacted] testified that the imaging tests merely delayed the surgery and the MRA could have been done while Patient A was on the operating table, which is the standard of care.

[80] St. Ex. 2, p. WN 00031.
[81] T. p. 492.
[82] Resp. Ex. 3, p. WN 00909.

He pointed to an article quoted in his report that found intraoperative angiography is beneficial in 90% of patients in helping avoid amputation.[83]

Dr. [redacted] testified that the delay in getting to surgery was acceptable based on the Respondent's opinion that Patient A had a viable foot which responded to pinprick and showed slow capillary refill. He agreed that if a patient has severe ischemia with no sensation, the surgery should be scheduled as an emergency. In this case, he agreed with the Respondent's assessment that extra time was required to give Patient A fluids and antibiotics to prepare her for surgery on June 4, 2014. He said no harm came of the delay and it did not factor into her death over one month later.

The State pointed out that [redacted]'s policy is for emergent cases to bump other emergencies and Dr. [redacted] discussed how vascular surgeons must push for their surgeries to take precedence over others due to the emergent nature of many of their surgeries. I note that the delay in getting Patient A to surgery is what prompted [redacted] to conduct an FPPE.

Regarding his delay in getting Patient A to surgery on June 4, 2014, the Respondent's surgical note blamed a ten-hour delay in starting the surgery on emergencies in the operating room;[84] his Summary of Care blamed it on the CT scan being cancelled and then having to wait on the results of the MRA;[85] and in his cross-examination, he said that he tried to move the surgery up and that he "stewed in a corner" over his inability to move it up.[86]

These inconsistencies are troubling and point to a delay in the surgery that was not justified, particularly in light of the information provided in the summary of the Medical Executive Committee revealing that the Respondent conducted another surgery that afternoon.[87]

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[83] The article extract appears on page 10 of Dr. [redacted]'s report. St. Ex. 12.
[84] Resp. Ex. 3, p. WN 00972.
[85] St. Ex. 5, p. WN 00456.
[86] T. pp. 624-25.
[87] St. Ex. 2, p. WN 00031.

This failure of the Respondent to provide a consistent answer affects his credibility generally and specifically on other matters he testified to that are not documented, such as whether he conducted a complete vascular examination on June 2, 2014 when Patient A was admitted, his conversations about moving the time of Patient A's surgery up, and his purported conversations with Patient A regarding a possible bypass during the exploratory surgery on June 3, 2014, which is discussed below.

Informed Consent

The Respondent is charged with failing to obtain proper informed surgical consent prior to the June 3, 2014 surgery because he did not include the possibility of a bypass procedure on the consent form.[88]

The Respondent testified that he knew Patient A's daughter before June 2, 2014, because she was a certified nursing assistant at [redacted] This caused him to remember many more details regarding Patient A's case than he might otherwise have remembered, he said. He also recalled more details, he said, because he had to review the medical records in 2017 when the FPPE was initiated. He said he recalled in detail Patient A's condition in the emergency department and his decision to admit her to the ICU to be put on antibiotics and fluids.

Regarding the informed consent for the June 3, 2014, surgery, the Respondent testified that he recalled the conversation he had with the family and knows he would have told them all the possible risks. He said there were too many possibilities to include them all in the consent form and remembers telling them that he would "do whatever I have to do to fix the problem."[89] He knew he would not perform a bypass intraoperatively due to Patient A's condition which is why he did not include it in the written consent. Once he was inside and could see her vessels

[88] Resp. Ex. 3, p. WN 00942.
[89] T. p. 469.

and muscle, he knew he would need to remove some calcification and friable vessels before deciding whether to do a bypass. He said a bypass always follows a ligation, but the question is *when* that needs to take place. His work with IV-using drug abusers had convinced him that bypass did not always need to be done immediately.

Dr. [redacted] pointed out the importance of reducing everything to writing in medical records, to provide "continuity of care" and prevent lawsuits. When pressed, Dr. [redacted] agreed that if a surgeon thought the patient had only an infected hematoma, the consent form covering only evacuation and drainage would be appropriate. However, he testified that when addressing complications from a cardiac catherization, it would be "naïve" to think that the patient might not have a pseudoaneurysm[90] and that a bypass would not be necessary.[91] Dr. [redacted] believed the consent form as written for June 3, 2014 was sufficient, as not everything can realistically be included and the Respondent probably did not think he would be doing a bypass in that surgery.

The Respondent argued that placing a bypass in an infected area during the exploratory surgery would not have met the standard of care and that is true. But Dr. [redacted] did not testify that the bypass would go through the infected area; rather, it would bypass the infected area. Thus, so long as the patient is hemodynamically stable, proceeding with a bypass immediately following ligation would be appropriate.

Furthermore, the Respondent argued strenuously that he knew Patient A had a hematoma, not a pseudoaneurysm, and that influenced what he included in the consent form, but Dr. [redacted] documented his discussion with the Respondent on June 2, 2014 and noted specifically that "this patient probably has an abscess of the right femoral artery with a pseudoaneurysm."[92] The

[90] Pseudoaneurysm is a leaking blood vessel causing blood to collect in surrounding tissue.
[91] T. p. 299.
[92] Resp. Ex. 3, p. WN 00869.

Respondent testified that he relied on the CT scan, which was performed without contrast by Dr. [redacted], to conclude that nothing suggested a pseudoaneurysm, but Dr. [redacted]'s impression was: "Possible right groin hematoma, as described above. Other etiologies cannot be excluded."[93] This CT scan did not rule out a pseudoaneurysm or the need for a bypass.

I accept Dr. [redacted]'s opinion on the matter of the informed consent on June 3, 2014. Including bypass as a possibility during the initial exploratory surgery and ligation of the artery is not tantamount to including every possible action that might ever occur during such a surgery, but it is a likely outcome. Indeed, the Respondent testified bypass always follows ligation and he testified that he did talk to the family about it, he just did not reduce it to writing. If bypass was significant enough to discuss with the family prior to the June 3, 2014, surgery, it was significant enough to be included in the consent form.

Medical Documentation

Regarding documenting a complete vascular examination of Patient A on June 2, 2014, the Respondent testified that he recalled conducting such an examination. He said he did not document his evaluation of her legs because he has a habit of only "documenting positives or pertinent negatives."[94] He did not conduct a Doppler at that point because he could palpate the pulses himself. He discerned the situation immediately and knew he would have to operate on her. He said there is no need to write everything down when he is "standing right there."[95]

Dr. [redacted] testified to the elements of a complete vascular examination, which includes checking for pedal pulses and documenting the appearance of the feet for comparison the next day. He said the Respondent's report only mentioned checking Patient A's right groin, which was the area she complained of. He noted that the cardiologist did check her pedal pulses.

[93] Resp. Ex. 3, p. WN 01181.
[94] T. p. 460.
[95] T. p. 598.

Dr. Snyder conceded that additional documentation by the Respondent would have been helpful to planning her treatment. Yet he also said that some of Dr. [redacted]'s complaints were "picayune," which offended Dr. [redacted], who protested they were not picayune at all, but represented appropriate medical practice.

Dr. [redacted] testified he is not a chart expert. He said he simply assumed the Respondent conducted a complete vascular examination, even though it was not documented. He believes if a treatment plan is documented, that should suffice.

Adequate medical documentation is basic to providing a patient with continuity of care and avoiding later questions regarding treatment. It also avoids litigation. I accept Dr. [redacted]'s testimony regarding the central role it plays in medical treatment and in the documentation deficits in this case by the Respondent.

Nor did the Respondent adequately document his examination of the Patient on the morning of June 4, 2014. Much time was spent at the hearing deciphering his notes to determine whether they revealed that he did, in fact, examine the Patient. Better documentation would have made that clearer without having to sleuth out medical records.

For all of those reasons, as to Patient A, I conclude the Respondent violated the standard of care and failed to keep accurate medical documentation, as alleged in the Charges.

Patient B

The Charges alleged that the Respondent failed to document the intraoperative placement of a drain, the amount of post-operative drainage, or the removal of a drain in his medical records for Patient B and failed to accurately document Patient B's condition. There is no allegation that the Respondent failed to meet the standard of care regarding Patient B.

Dr. [redacted] and Dr. [redacted] agreed that no drain was required in Patient B's surgery. Dr. [redacted] testified that he believes no drain was placed.[96]

As noted in the Findings of Fact, the Respondent explained that the drain issue was created when he wrote in his Summary of Care presented to the Board that he placed a drain, when he meant to write that he placed a dressing.[97] I found the Respondent believable on this issue because no drain is mentioned in the medical documentation prepared at the time of Patient B's surgery; no drain is required by the standard of care in the type of surgery he had; and the words drain and dressing are similar enough that one can see how they might be confused. The only troubling aspect is that it suggests sloppiness by the Respondent.

The State argued that the contradiction in the documentation is not minor, and the allegation should be upheld. However, the documentation that created the issue was composed in response to the Charges, not as part of the original medication documentation. It is disingenuous to hold the Respondent responsible for improper medical documentation for an unintentional error in a report that post-dated the Charges.

Regarding the second allegation, that the Respondent failed to document Patient B's condition, the State did not make clear the basis of this allegation. I presume it was based on the lack of documentation of a drain. At any rate, the evidence did not support this allegation, either.

Patient C

There are three allegations in the Charges regarding Patient C. The Respondent is alleged to have violated the standard of care in two respects: failing to actively monitor a critically ill patient with known risk factors for developing gangrene and failing to consult the daily chart wound assessment and treatment notes prepared by the Hospital staff. The

[96] T. pp. 203, 210.
[97] St. Ex. 7.

Respondent is alleged to have failed to keep adequate medical records by "documenting a lack of knowledge of Patient C's condition, which in fact had been previously established, leading to inaccurate or contradictory medical records."

Standard of Care

Patient C arrived at the emergency department of [redacted] on August 21, 2017, at 11:33 a.m. with a constellation of serious medical conditions exacerbated by an infected AV graft in her right groin the Respondent had inserted on August 2, 2017. The Respondent discussed her condition by telephone with the emergency department physician twice on August 21, 2017, and determined, based on that doctor's observations, that Patient C did not have a necrotizing infection. He also believed her symptoms did not indicate sepsis. Thus, he waited until the next day to examine her.

On August 22, 2017, her INR was 4.29, up from 3.4 the previous day. The Respondent continued to believe that she was bacteremic, not septic. He knew that her infected graft would have to be removed. He did not want to proceed to surgery until her INR was below 2. On August 23, 2017, her INR was down to 1.83, but he decided to optimize her for surgery and so he ordered three units of packed red blood cells and two units of fresh frozen plasma with dialysis that day. Surgery was scheduled for August 24, 2017, and took place between 5:26 p.m. and 7:15 p.m. He removed the infected graft and performed extensive radical wound debridement. Patient C died on August 27, 2017, having suffered cardiac arrest the previous day.

The State argued that the Respondent violated the standard of care by failing to personally examine Patient C when she was admitted to [redacted] on August 22, 2017, waiting too long to take Patient C to surgery, and failing to be familiar with the documentation regarding her infected right thigh wound. Dr. [redacted] was adamant that the standard of care required the

Respondent to examine Patient C on the day she was admitted due to her signs of sepsis, the advanced infection around the graft which the Respondent had inserted earlier that month, and the possibility of necrotizing fasciitis.[98] He said it was not enough to simply rely on the observations of the emergency department physician, particularly when the radiologist recommended clinical correlation after the CT scan was done.[99]

Dr. [redacted] did not see a problem in the Respondent's failure to examine Patient C on August 21, 2017 and testified that her condition was not emergent and that she was fairly stable. He agreed with the Respondent that she needed a "tune-up" before going into surgery and found no fault with delaying until August 24, 2017.[100] The Respondent believed he could depend on the observations of the emergency department physician and radiologist and saw no reason to examine her on the day she was admitted.

A great deal of time was spent during witness testimony establishing whether Patient C was septic. Dr. [redacted] opined that she was septic, noting her high white blood cell count of 24,000, low blood pressure, altered mental state, the red, tender area around the thigh, and her elevated lactate. He noted the emergency department concluded she was septic and that she was unresponsive upon admission, although later, another physician reported she was mentating well. Her fever was not particularly high. Dr. [redacted] emphasized that because Patient C presented at the hospital with an infection from a graft that the Respondent had placed, he was responsible for examining her upon her admission.

The Respondent believed Patient C was bacteremic, but not septic. Dr. [redacted] testified there are stages of sepsis and there was no emergency unless Patient C developed septic shock.

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[98] T. p. 224.
[99] T. pp. 218-19, 225; CT scan at Resp. Ex. 7, pp. 05694-95.
[100] T. p. 687.

He agreed she had some elements of sepsis, however, and wrote in his report that she had "signs and symptoms" of sepsis.[101] He said that if a patient has bacteremia, they probably have sepsis.

Dr. [redacted] emphasized in his testimony that once a patient presents with an infected graft, there is nothing that can be done short of removing the graft and that antibiotics cannot eradicate the infection. He repeated that the "longer you wait, the greater the risk."[102] His opinion was that the Respondent should have taken Patient C to surgery no later than August 23, 2017, testifying that she could have been transfused during surgery rather than in a separate dialysis session. Dr. [redacted] agreed with the Respondent that it was more important to optimize the patient for surgery than rush to remove the graft. Dr. [redacted] did not see her condition as bad enough that it was worth the risk of proceeding to surgery before she had a transfusion.

The State initially argued that the Respondent did not examine Patient C for almost thirty hours after admission, but it was established, through the notes of Dr. [redacted], that the Respondent did see her the morning after her admission; he just did not document his examination until later that evening.

Another focus of the expert testimony was whether the Respondent should have been more concerned at the time of Patient C's admission that she might develop necrotizing fasciitis. Dr. [redacted] testified that the Respondent was obligated by the standard of care to examine Patient C personally to rule out necrotizing fasciitis, given the suggestion of gas in the soft tissue by the CT scan. Had the Respondent confirmed necrotizing fasciitis, the standard of care would have required radical debridement and transfer to an institution that could supply hyperbarics.[103] The Respondent was wrong to diagnose it based solely on the observations of others, he said.

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[101] Resp. Ex. 11, p. 9.
[102] T. p. 253.
[103] T. p. 224.

Dr. [redacted] accepted the Respondent's view that the CT scan ruled out necrotizing fasciitis, but Dr. [redacted] disagreed, noting that the radiologist called for clinical correlation. The Respondent was confident, based on the observations of the emergency department physician, that Patient C did not have necrotizing fasciitis and decided he did not need to examine her on August 22, 2017, but could wait until the following day.

The State also argued the Respondent unreasonably delayed getting Patient C to surgery, although the evidence revealed that Patient C was not sufficiently hemodynamically stable to go into surgery the first or even the second day. I accept Dr. [redacted]'s testimony, however, that she would have been stable enough to go into surgery the third day, August 23, 2017, because she could have received a transfusion during surgery. Her INR was under 2 and, under the Respondent's plan, she could be taken to surgery at that point. Dr. [redacted] saw the situation as far more emergent than either Dr. [redacted] or the Respondent. I was struck during the testimony by how much Dr. [redacted] and the Respondent seemed to downplay the severity of Patient C's condition, given her constellation of issues. Dr. [redacted] expressed much more of a sense of urgency in getting her to surgery to remove the infected graft.

In defending his medical judgment, the Respondent wrote in his Summary of Care and Supplemental Board Response that an independent, out-of-state expert, a vascular surgeon named Dr. Woo, had reviewed the medical records and found "that the medical management was appropriate with NO quality issues (meets Standards of Practice)."[104] That was not Dr. [redacted]'s determination, however. Instead, Dr. [redacted] identified a judgment issue and concluded that the Case/Peer Review Issue was *possibly* preventable. Dr. [redacted] wrote that it was "unclear if demise was related to delay in surgery."[105] This mischaracterization of the evidence impacts my

[104] St. Exs. 9, 13.
[105] St. Ex. 2, pp. 00055.

assessment of the Respondent's credibility. It also supports Dr. [redacted]'s opinion that there was an issue with the Respondent's medical care.

The issue of not seeming to know about Patient C's right thigh wound was raised by the State as a violation of the standard of care as well as of medical documentation. The allegation stems from the Respondent's surgical note in Patient C's medical chart on August 24, 2017, that "It should be mentioned that upon lifting the stump, it was then realized that there was a large necrotic area on the posterior aspect of the thigh. When the patient was initially admitted, she never did allow for the stump to be touched, and therefore, this wound was overlooked by the team."[106]

The Respondent testified that the extent of the infected wound was not picked up until they turned her over in surgery. However, the wound care nurses noted the wound and treated it on August 23, 2017.[107] From the Respondent's testimony, I learned that, in fact, he was told about the wound on August 23, 2017, by the wound care nurses. He told the nurse he would look at it in surgery the following day.[108] This fact makes his note about the wound being overlooked even more confusing.

The Respondent refused to take any responsibility for knowing Patient C had an infected wound on her right thigh. He was adamant that he is not a wound specialist and treatment of such a wound is not done by a vascular surgeon, but a general surgeon. He did not testify that he had reviewed the wound care notes of Patient C, which goes to the heart of this allegation.

Dr. [redacted] asserted that the Respondent should have known about the wound and should have read the nursing notes about it from the previous day but conceded that he did not

[106] Resp. Ex. 7, p. WN 05848.
[107] Resp. Ex. 7, p. WN 06252.
[108] T. pp. 566-67.

mention the issue in his report to the Board.[109] In fact, this is not mentioned at all in the reports of Dr. [redacted] or Dr. [redacted] Nevertheless, although it might not have been the Respondent's responsibility to treat the infected thigh wound, it certainly is incumbent on a surgeon to be familiar with a patient's chart and accurately report what was known about the wound in his surgical notes. The Respondent offered no credible response to the allegation that he was apparently not familiar with the nursing notes of August 23, 2017.

Medical Documentation

The note the Respondent included in the surgical documentation may technically be correct, that the thigh wound was not seen at the time of admission, but it left the impression that no one knew about it until surgery, which was incorrect. He testified that he was not trying to deflect responsibility for knowing about the wound onto someone else, as the comment about the team overlooking the wound might suggest. In his Supplement Board Response, the Respondent did not address the medical documentation issue at all. There really was no credible response to the allegation that the surgical note was at worst, incorrect and at best, misleading.

For all of these reasons, as to Patient C, I conclude the Respondent violated the standard of care and documenting a lack of knowledge of her condition, as alleged in the Charges.

Sanctions

Disciplinary proceedings against a physician are not intended to punish the offender but rather "as a catharsis for the profession and a prophylactic for the public." *McDonnell v. Comm'n on Medical Discipline*, 301 Md. 426, 436 (1984). The Court of Special Appeals of Maryland has held that an administrative agency with disciplinary and licensing authority "has broad latitude in fashioning sanctions within [those] legislatively designated limits" so that it

[109] T. p. 410; St. Ex. 12.

may place conditions on any suspension or probation. *Cornfeld v. State Bd. of Physicians*, 174 Md. App. 456, 486 (2007) (citing *Neutron Prods., Inc. v. Dep't of Env't*, 166 Md. App. 549, 584 and *Blaker v. State Bd. of Chiropractic Examiners*, 123 Md. App. 243, 264-65, cert. denied, 351 Md. 662 (1998)). "Nevertheless, because there is a punitive aspect to the proceedings, statutes which authorize the imposition of sanctions against the licensed professional should be strictly construed against the disciplinary agency." *McDonnell*, 301 Md. at 436.

Under sections 14-404(a)(22) and (40) of the Health Occupations Article and the cases cited above, and subject to the Respondent's right to this hearing, a disciplinary panel may reprimand any licensee, place any licensee on probation and establish conditions of probation, or suspend or revoke a license if the licensee 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 fails to keep adequate medical records as determined by appropriate peer review.

The Board's regulations include a sanctioning matrix that reflects the minimum and maximum penalties for conduct that is subject to disciplinary action. COMAR 10.32.02.10. Under this matrix, the maximum penalty for a violation of section 14-404(a)(22) of the Health Occupations Article is revocation of the Respondent's license, and the minimum penalty is a reprimand. The maximum fine for violation of this section is $50,000.00, and the minimum fine is $5,000.00.

Under this matrix, the maximum penalty for violation of section 14-404(a)(40) of the Health Occupations Article is suspension of the Respondent's license for one year, and the minimum penalty is a reprimand. The maximum fine for violation of this section is $50,000.00, and the minimum fine is $2,500.00.

The Board's regulations also identify mitigating and aggravating factors for imposing a penalty outside of the regulatory range. Mitigating factors include:

(a) The absence of a prior disciplinary record;
(b) The offender self-reported the incident;
(c) The offender voluntarily admitted the misconduct, made full disclosure to the disciplinary panel and was cooperative during the disciplinary panel proceedings;
(d) The offender implemented remedial measures to correct or mitigate the harm arising from the misconduct;
(e) The offender made good faith efforts to make restitution or to rectify the consequences of the misconduct;
(f) The offender has been rehabilitated or exhibits rehabilitative potential;
(g) The misconduct was not premeditated;
(h) There was no potential harm to patients or the public or other adverse impact; or
(i) The incident was isolated and is not likely to recur.

COMAR 10.32.02.09B(5).

Aggravating factors may include, but are not limited to, the following:

(a) The offender has a previous criminal or administrative disciplinary history;
(b) The offense was committed deliberately or with gross negligence or recklessness;
(c) The offense had the potential for or actually did cause patient harm;
(d) The offense was part of a pattern of detrimental conduct;
(e) The offender committed a combination of factually discrete offenses adjudicated in a single action;
(f) The offender pursued his or her financial gain over the patient's welfare;
(g) The patient was especially vulnerable;
(h) The offender attempted to hide the error or misconduct from patients or others;
(i) The offender concealed, falsified or destroyed evidence, or presented false testimony or evidence;
(j) The offender did not cooperate with the investigation; or
(k) Previous attempts to rehabilitate the offender were unsuccessful.

COMAR 10.32.02.09B(6).

I have set forth the Board's requested sanctions above. Based on my findings and the arguments of the parties, I agree with the Respondent that the requested sanctions are too severe. I have found violations of the standard of care and in the Respondent's medical recordkeeping. I have found that inconsistencies in the Respondent's responses to the allegations impacted his credibility. A risk of harm was shown in Patient A's care, where the delay in getting her into

surgery could have impacted the likelihood of amputation. Nevertheless, I do not find his actions to have been as egregious as the State asserts.

The State argues that there is one mitigating factor: (a) The absence of a prior disciplinary record. The State argues that there are four aggravating factors: (c) Potential for harm or did cause harm; (d) Pattern of detrimental conduct; (e) Several discrete acts adjudicated in a single action; (k) Previous attempts to rehabilitate were unsuccessful. I do not find that (k) applies to the evidence, as the record is not complete regarding the outcome of the FPPE at [redacted], but only that an FPPE was conducted. The record supports the other aggravating factors.

The Respondent argued there are four mitigating factors: (a) The absence of a prior disciplinary record; (f) The Respondent exhibits rehabilitative potential; (g) Misconduct was not premeditated; (h) There was no potential harm. I agree the record supports the first three mitigating factors. The record does not support a finding under (h) that there was no potential harm to the patients.

The Respondent asked that for guidance I look to the sanctions that were considered by the [redacted] Medical Executive Committee at the time he resigned. He also noted that none of the Charges arose from his surgical skill, but only decisions he made prior to or after surgery. He argued that he is primarily performing endovascular work now, not emergent surgeries. He intends to retire in about two years.

The State argued that the Respondent should be subject to a $25,000.00 fine because he was contemptuous of the disciplinary process. I did not see contempt during the hearing or in the record. He, like the expert witnesses, was extremely confident in his opinions; some might say arrogant. Additionally, the Respondent did often have difficulty remembering certain details of the cases and of his disciplinary processes that took place at [redacted] and [redacted], but that did not rise to the level of contempt. This is a doctor who has practiced for over thirty years, always

with a vulnerable patient population. He has been questioned by hospital medical executive committees previously, but never brought before the Board on disciplinary charges. He is near retirement. He is understandably distraught about the Charges and the impact this process could have on his license to practice medicine. I saw nothing that would warrant the imposition of a $25,000.00 fine, however, on the basis that he has contempt for the process or the Board. The record supports the minimum fine for a violation of the standard of care, $5,000.00.

The Respondent requested a reprimand rather than a suspension, but pursuant to COMAR 10.32.02.10A(3)(b), where conditions are attached as part of probation, the sanction is a stayed suspension rather than a reprimand. As even the Respondent's proposed sanctions include conditions attached to the probation, a stayed suspension is proper rather than a reprimand.

Taking into account the evidence presented, the mitigating and aggravating factors, and the arguments of the parties, I find the following represents an appropriate sanction: a stayed suspension; two years of probation wherein the Respondent is supervised; no emergency procedures or On Call in a hospital setting while on probation; professional competency evaluation; medical record keeping course within six months; and a $5,000.00 fine.

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude as a matter of law that as to Patient A and Patient C, the Respondent violated the alleged provisions of the law. Md. Code Ann., Health Occ. § 14-404(a)(22) and (40) (Supp. 2020). As a result, I conclude that the Respondent is subject to disciplinary sanctions for the cited violations as follows: a stayed suspension; two years of probation wherein the Respondent is supervised; no emergency procedures or On Call in a hospital setting while on probation; professional competency evaluation; medical record keeping course within six months; and a $5,000.00 fine. *Id.*; COMAR 10.32.02.09A(3), B.

Based on the foregoing Findings of Fact and Discussion, I conclude as a matter of law that as to Patient B, the Respondent did not violate the alleged provisions of the law. Md. Code Ann., Health Occ. § 14-404(a) (40) (Supp. 2020).

PROPOSED DISPOSITION

I **PROPOSE** that charges filed by the Maryland State Board of Physicians against the Respondent on July 6, 2020 as to Patient A and Patient C be **UPHELD**; and

I **PROPOSE** that the Respondent be sanctioned as follows: a stayed suspension; two years of probation wherein the Respondent is supervised; no emergency procedures or On Call in a hospital setting while on probation; professional competency evaluation; medical record keeping course within six months; and a $5,000.00 fine.

I **PROPOSE** that charges filed by the Maryland State Board of Physicians against the Respondent on July 6, 2020 as to Patient B be **DISMISSED**.

Joy L. Phillips

July 6, 2021
Date Decision Issued

Joy L. Phillips
Administrative Law Judge

JLP/dlm
#191511

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party adversely affected by this proposed decision may file written exceptions with the disciplinary panel of the Maryland State Board of Physicians that delegated the captioned case to the Office of Administrative Hearings (OAH) and request a hearing on the exceptions. Md. Code Ann., State Gov't § 10-216(a) (2014); COMAR 10.32.02.05. Exceptions must be filed within fifteen (15) days of the date of issuance of this proposed order. COMAR 10.32.02.05B(1). The exceptions and request for hearing must be addressed to the Disciplinary Panel of the Board of Physicians, 4201 Patterson Avenue, Baltimore, MD, 21215-2299, Attn: Christine A. Farrelly, Executive Director.

A copy of the exceptions should be mailed to the opposing attorney, and the other party will have fifteen (15) days from the filing of exceptions to file a written response addressed as above. *Id.* The disciplinary panel will issue a final order following the exceptions hearing or other formal panel proceedings. Md. Code Ann., State Gov't §§ 10-216, 10-221 (2014); COMAR 10.32.02.05C. The OAH is not a party to any review process.

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