IN THE MATTER OF	*	**BEFORE THE**
JULIA E. OLSON, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D90487	*	**Case Number: 2223-0105B**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of **JULIA E. OLSON, M.D.** (the "Respondent"), License Number D90487, to practice medicine in the State of Maryland.

Panel B takes such action pursuant to its authority under Md Code Ann., State Gov't ("State Gov't") §10-266(c)(2) (2022 Repl. Vol.) and Md. Code Regs. ("COMAR") 10.32.02.08B(7), concluding that the public health, safety, or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

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

[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with reasonable notice of the basis of Panel B's action. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

Panel B is summarily suspending the Respondent's license to practice medicine after a Board investigation determined that she has a health condition that affects her ability to practice medicine safely.

I. BACKGROUND

1. The Respondent was originally licensed to practice medicine in Maryland on November 2, 2020, under License Number D90487. The Respondent's license is scheduled to expire on September 30, 2023.

2. The Respondent is Board-Certified in Anesthesiology.

3. At all times relevant hereto, the Respondent practiced as an anesthesiologist at a health care facility (the "Facility")[2] in Maryland.

II. THE COMPLAINT

4. On or about March 28, 2023, the Board received a Mandated 10-Day Report[3] (the "Report") stating that "on March 20, 2023, [the Respondent] was delivering general anesthesia to a patient in the [Facility's] operating room" when she "collapsed to the floor, and was found to be unconscious and cyanosed."[4] The Respondent requested and was granted a leave of absence from the Facility.

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[2] To maintain confidentiality, the names of healthcare facilities and individuals will not be identified in this document. The Respondent may obtain the names of the health care facilities, individuals, and medications referenced herein by contacting the administrative prosecutor.

[3] *See* Health Occ. § 14-413.

[4] "Cyanosis" - a bluish or purplish discoloration (as of skin) due to deficient oxygenation of the blood Merriam-Webster.com Medical Dictionary, Merriam-Webster.

III. BOARD INVESTIGATION

5. The Board initiated an investigation based on the Report from the Facility. As a part of the investigation, Board staff interviewed witnesses and obtained the Respondent's medical records.

Nurse A

6. On May 3, 2023, Board staff conducted an under-oath interview of a registered nurse ("Nurse A") who directly observed the Respondent in the operating room on March 20, 2023.

7. Nurse A stated that she walked into the operating room at approximately 11:00am to relieve another nurse for her lunch break. While Nurse A and the Respondent were talking, the Respondent lifted up a bottle of Versed and asked Nurse A to look at a vial to confirm that it was empty. Nurse A confirmed that the vial was empty and the Respondent asked Nurse A to waste[5] the bottle with her so that the Respondent could pull out another vial to provide to the patient before they woke up. The Respondent properly completed the waste with Nurse A. Approximately twenty minutes later, Nurse A heard a loud crash and the Respondent was found unconscious on the floor of the operating room.

8. Nurse A further reported that the Respondent was not breathing but did have a pulse. The physicians and staff in the operating room at the time were able to revive the

[5] Nurse A explained that a waste occurs when there is medication leftover and it must be documented in the Cactus disposal system that is attached to the Pyxis. The medication is to be deposited into the Cactus system and the clinician is to dispose of the syringe, vial, needle, etc. in front of the nurse who then confirms the waste electronically with a fingerprint in the Pyxis system.

Respondent. Nurse A then noticed a syringe sticking out of the Respondent's left sock which was attached to tubing and an angiocath in the Respondent's foot.

9. Nurse A asked the Respondent what the angiocath was and whether it was used to inject the Versed that Nurse A had just "wasted" with the Respondent. The Respondent stated that it was not the Versed but rather Propofol. Nurse A looked at the syringe and confirmed that the substance was a cloudy white substance that is indicative of Propofol.

10. The Respondent was then transported to the emergency room department at the Facility for an evaluation.

Locker Search

11. Board staff also conducted an under-oath interview of a senior nursing director ("Senior Nurse") who deals with issues regarding the medical staff at the Facility and the director of nursing at the Facility ("Nurse Director").

12. The Senior Nurse and Nurse Director stated that as a result of the Respondent's collapse in the operating room and subsequent admission to diverting medication, a search of the Respondent's locker was initiated to determine if the Respondent had any additional narcotics or illegal substances in her possession. During the search, two vials of a rocuronium reversal were found along with a tube of lidocaine hydrochloride jelly.

13. The Respondent also provided verbal consent to allow the Senior Nurse and Facility staff to look inside her purse where two packaged blunt tip needles were located.

Physician Supervisor

14. On May 17, 2023, Board staff conducted an under-oath interview of a physician ("Physician Supervisor") who deals with issues regarding the medical staff at the Facility.

15. The Physician Supervisor met with the Respondent. The Respondent admitted that she had been using controlled dangerous substances for three to four months and admitted to diverting the medication. The Respondent specifically admitted to using Dilaudid, Fentanyl, Versed and Propofol. The Respondent stated that she would provide the patient with what was needed and save the remaining medication in a clean syringe and use it at a later time. The Respondent would then inject saline in the syringe to make it appear that the medication was being properly discarded pursuant to the proper waste procedures.

16. The Respondent submitted a one-year leave of absence from the Facility.

Respondent's Admission

17. The Board notified the Respondent of its investigation by letter dated April 26, 2023 and directed her to provide a written response.

18. By letter dated May 11, 2023, the Respondent, through counsel, provided a written response to the Board.

19. In the response, the Respondent admits that "when she collapsed during a procedure on March 20, 2023, she was found with a syringe and IV catheter attached to her foot." The Respondent "acknowledges and understands that there is no excuse for such behavior - especially while providing patient care."

CONCLUSION OF LAW

Based upon the foregoing Investigative Findings, Panel B of the Board concludes that the public health, safety, or welfare imperatively requires emergency action, and that pursuant to State Gov't § 10-226(c)(2) and COMAR 10.32.02.08B(7), the Respondent's license is summarily suspended.

ORDER

IT IS thus, by Panel B of the Board, hereby:

ORDERED that pursuant to the authority vested in Panel B by State Gov't. §10-226(c)(2)(2021 Repl. Vol.) and COMAR 10.32.02.08B(7), the Respondent's license to practice medicine in the State of Maryland is hereby **SUMMARILY SUSPENDED**; and it is further

ORDERED that, during the course of the summary suspension, the Respondent shall not practice medicine in the State of Maryland; and it is further

ORDERED that in accordance with Md. Code Regs. 10.32.02.08B(7) and E, a post deprivation initial hearing on the summary suspension will be held on **Wednesday, June 28, 2023, at 11:30 a.m.** at the Board's offices, located at 4201 Patterson Avenue, Baltimore, Maryland 21215-0095; and it is further

ORDERED that after the **SUMMARY SUSPENSION** hearing before Panel B, the Respondent, is dissatisfied with the result of the hearing, may request, within ten (10) days, an evidentiary hearing, such hearing to be set within thirty (30) days of the request, before

an Administrative Law Judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031-1301; and it is further

ORDERED that a copy of the Order for Summary Suspension shall be filed by Panel B immediately in accordance with Health Occ. § 14-407(a)(2021 Repl. Vol.); and it is further

ORDERED that this is a disciplinary Order of Panel B, and as such, is a public document. See Health Occ. §§ 1-607, 14-411.1(b)(2) and Md. Code Ann., Gen Prov. §4-333(B)(6).

06/15/2023
Date

Signature On File

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