

IN THE MATTER OF * BEFORE THE MARYLAND
 KIRAN TARIQ, M.D. * STATE BOARD OF
 Respondent * PHYSICIANS
 License Number: D90803 * Case Number: 2223-0021

* * * * *

CONSENT ORDER

PROCEDURAL BACKGROUND

The Maryland Board of Physicians (the “Maryland Board”) received information that Kiran Tariq, M.D., (the “Respondent”) License Number D90803, was disciplined by the Virginia Board of Medicine (the “Virginia Board”). In an Order dated July 11, 2022, the Virginia Board reprimanded the Respondent.

Based on the above referenced Virginia Board sanction, the Maryland Board has grounds to charge the Respondent with violating the following provisions of the Maryland Medical Practice Act (the “Act”), under H. O. § 14-404(a):

- (a) 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:
 - (21) Is disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or disciplined by any branch of the United States uniformed services or the Veteran’s Administration for an act that would be grounds for disciplinary action under this section,

Disciplinary Panel A (“Panel A”) has determined that the acts for which the Respondent was disciplined in Virginia would be grounds for disciplinary action under

H.O. § 14-404(a). The grounds for disciplinary action under H.O. § 14-404(a) are as follows:

- (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[.]

Based on the action taken by the Virginia Board, the Respondent agrees to enter into this Consent Order with Panel A, consisting of Procedural Background, Findings of Fact, Conclusions of Law, Order and Consent.

FINDINGS OF FACT

Panel A makes the following findings of fact:

1. At all times relevant hereto, the Respondent was a physician licensed to practice medicine in the State of Maryland. The Respondent was initially licensed in Maryland on or about January 21, 2021.
2. The Virginia Board found that the Respondent failed to adequately evaluate and manage the treatment of a 34-year-old male patient with multiple chronic conditions, including neuromyopathy, seizures, paraplegia, dysphagia requiring a permanent jejunostomy feeding tube, chronic respiratory failure, total gastrectomy, and a history of multiple intra-abdominal infections with abscesses and sepsis, who had had his jejunostomy replaced earlier that day and was admitted for observation.
3. By Order dated July 11, 2022, the Virginia Board reprimanded the Respondent.

A copy of the Virginia Board Order is attached hereto.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel A concludes as a matter of law that the Respondent is subject to discipline under Health Occ. § 14-404(a)(21) for the disciplinary action taken by the Virginia Board against the Respondent for an act or acts that would be grounds for disciplinary action under Health Occ. §14-404(a)(22).

ORDER

It is, thus, by Panel A, hereby:

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

ORDERED that the effective date of the Consent Order is the date the Consent Order is signed by the Executive Director of the Board or her designee; and it is further

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

10/17/2022
Date

Signature on File

Christine A. Farrelly
Executive Director
Maryland Board of Physicians

CONSENT

I, Kiran Tariq, MD, acknowledge that I am aware of my right to consult with and be represented by counsel in considering this Consent Order. I have chosen to proceed without counsel and I acknowledge that the decision to proceed without counsel is freely and voluntarily made.

By this Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition.

BEFORE THE VIRGINIA BOARD OF MEDICINE

IN RE: KIRAN TARIQ, M.D.
License Number: 0101-257859
Case Number: 206980

ORDER

JURISDICTION AND PROCEDURAL HISTORY

Pursuant to Virginia Code §§ 2.2-4019 and 54.1-2400(10), a Special Conference Committee of the Virginia Board of Medicine (“Board”) held an informal conference on July 7, 2022, in Henrico County, Virginia, to inquire into evidence that Kiran Tariq, M.D., may have violated certain laws and regulations governing the practice of medicine in the Commonwealth of Virginia.

Kiran Tariq, M.D., appeared at this proceeding and was represented by Kristina Lewis, Esquire.

NOTICE

By letter dated March 2, 2022, the Board sent a Notice of Informal Conference (“Notice”) to Dr. Tariq notifying her that an informal conference would be held on July 27, 2022. The Notice was sent by certified and first class mail to the legal address of record on file with the Board. At Dr. Tariq’s request, the informal conference was rescheduled to July 7, 2022.

Upon consideration of the evidence, the Board adopts the following Findings of Fact and Conclusions of Law and issues the Order contained herein.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Kiran Tariq, M.D., was issued License Number 0101-257859 to practice medicine on March 3, 2015, which is scheduled to expire on September 30, 2022. At all times relevant to the findings contained herein, said license was current and active.
2. Dr. Tariq violated Virginia Code § 54.1-2915(A)(3) in that on the evening of July 7, 2016, while on duty as an on-call hospitalist for a Virginia hospital, she failed to adequately evaluate and

manage the treatment of Patient A, a 34-year-old male with multiple chronic conditions, including neuromyopathy, seizures, paraplegia, dysphagia requiring a permanent jejunostomy feeding tube (“J-tube”), chronic respiratory failure, total gastrectomy, and a history of multiple intra-abdominal infections with abscesses and sepsis, who had had his jejunostomy replaced earlier in the day and was admitted for observation. Specifically:

a. In a telephone call at approximately 6:46 p.m., nursing staff notified Dr. Tariq that Patient A had had a J-tube procedure earlier in the day and now was complaining of pain and had an elevated heart rate. Dr. Tariq did not inquire about any of Patient A’s other vital signs, nor did she examine Patient A. She ordered a dose of Dilaudid IV for pain. According to hospital records, before nursing staff contacted Dr. Tariq, Patient A’s oxygen saturation was 84% and his respiratory rate was 25.

b. In a telephone call at approximately 8:45 p.m., nursing staff notified Dr. Tariq that Patient A’s blood pressure was 71/40. Dr. Tariq did not inquire about any of Patient A’s other vital signs, nor did she examine him. She ordered IV fluids and, if Patient A’s blood pressure did not improve, albumin. Hospital records show that before nursing staff contacted Dr. Tariq, Patient A’s temperature was 102°F, his heart rate was 131, his respiration rate was 24, and his oxygen saturation was 70%, all of which indicated that Patient A was unstable and in distress.

c. In a telephone call at approximately 10:19 p.m., nursing staff notified Dr. Tariq that Patient A’s blood pressure had improved and was now 119/66. She was also notified that Patient A’s temperature had been high earlier but had returned to normal. Dr. Tariq did not inquire about any of Patient A’s vital signs, nor did she examine him. She ordered blood cultures and a Tylenol suppository. Further, upon being informed that Patient A’s tube feeding had resumed, she ordered that the feeding be discontinued and ordered an abdominal radiograph to determine if he had ileus or an obstruction.

According to hospital records, at the time nursing staff contacted Dr. Tariq, Patient A 's respiration rate was 44 and his heart rate was 121, all of which indicated that Patient A continued to be unstable and in severe distress.

3. Patient A's condition declined further and he was found to have sepsis and a perforated bowel. He expired on July 12, 2016.

4. At the informal conference, Dr. Tariq noted that the vital signs in the record were recorded by the nurse at around 7:00 p.m., which was after the phone call she received at 6:46 p.m. However, the patient was on continuous monitoring, so the nurse may have been reporting to Dr. Tariq what he could see on the screen during the phone call.

5. Dr. Tariq stated that it was her habit and practice to ask about patients' vital signs, and if she was informed that they were normal, then she would trust the nurses. She said she was informed that Patient A's vital signs were normal and he had not been complaining about pain, so she had the impression that his vital signs had improved and he was otherwise stable.

6. At the informal conference, Dr. Tariq said that from the way she was getting information from the nurses, it appeared to her that the patient's vital signs had improved throughout the night at various times, and she was never informed that the patient was in distress. She noted that the patient was tachycardic after the J-tube procedure and had complained of pain at that time, but then certain vital signs returned to normal. She stated that the patient's fever was not sustained, and so she thought that it was transient or reactive.

7. Dr. Tariq said that it was not uncommon to get multiple calls from the nurses about the same patient in this hospital. The way she received the calls was different from the way they were charted.

8. Dr. Tariq stated that she currently practices in another setting that she believes is safe. She has a reasonable number of patients to manage and trusts the nurses to contact her and give her accurate information. She said that she keeps a higher level of suspicion now when being told of an abnormal vital sign. In her current practice, if a patient has recently undergone a procedure earlier in the day (as Patient A had), she ensures that the specialist is consulted if there are any changes in the patient's clinical situation.

9. Dr. Tariq stated that she has learned from this incident and will ensure that she is never in a setting where she is responsible for an unsafe number of patients that does not allow her adequate time to do all of her due diligence. When she is told that a patient's vitals are "fine," she now asks for the specific numbers. She stated that she holds her responsibility for her patients with the utmost regard.

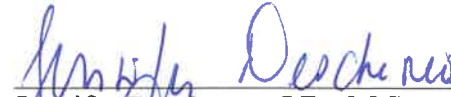
10. In a written statement to an investigator for the Department of Health Professions, Dr. Tariq acknowledged that she did not gather sufficient information to assess Patient A's condition before directing nursing staff regarding his treatment.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Virginia Board of Medicine hereby ORDERS that Kiran Tariq, M.D., is REPRIMANDED.

Pursuant to Virginia Code §§ 2.2-4023 and 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD



Jennifer Daschenes, J.D., M.S.
Deputy Executive Director
Virginia Board of Medicine

ENTERED AND MAILED: July 11, 2022

NOTICE OF RIGHT TO APPEAL

Pursuant to Virginia Code § 54.1-2400(10), Dr. Tariq may, not later than 5:00 p.m., on August 15, 2022, notify William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that she desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated. This Order shall become final on August 15, 2022, unless a request for a formal administrative hearing is received as described above.