IN THE MATTER OF	*	**BEFORE THE**
NINA S. SLOAN	*	**MARYLAND STATE**
Applicant for Reinstatement	*	**BOARD OF PHYSICIANS**
Former License No.: L03062	*	**Case No.: 8821-0002A**

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ORDER ON APPLICATION FOR REINSTATEMENT OF RESPIRATORY CARE PRACTITIONER LICENSE

INTRODUCTION

On March 27, 2009, the Maryland State Board of Physicians (the "Board") issued a Final Decision and Order revoking the respiratory care practitioner license of Nina S. Sloan, based on the Board's findings that Ms. Sloan failed to comply with a Board Order that required her to complete a Board-approved ethics course during probation. *See* Md. Code Ann., Health Occ. § 14-5A-01 *et seq.* On October 9, 2020, the Board received Ms. Sloan's application for the reinstatement of her license. On March 10, 2021, Disciplinary Panel A[1] met with Ms. Sloan to consider her application for the reinstatement of her license.

DISCIPLINARY HISTORY

August 19, 2005 Final Decision and Order

On August 19, 2005, following an evidentiary hearing at the Office of Administrative Hearings ("OAH") before an Administrative Law Judge and an Exceptions hearing before the Board, the Board found that Ms. Sloan administered Levalbuterol directly into the endotracheal tube of a critically ill female infant in a hospital's neonatal intensive care unit ("NICU") without a physician's order, which resulted in further medical destabilization of the infant. The medication

[1] In 2013, the Board was divided into two disciplinary panels to resolve disciplinary actions against physicians and allied health professionals. *See* 2013 Md. Laws, ch. 401, amending Md. Code Ann., Health Occ. § 14-401.

had not been prescribed for the infant. Ms. Sloan was the respiratory care practitioner assigned to the infant who was admitted to the NICU with diagnoses of Group B streptococcus pneumonia and persistent pulmonary hypertension. The infant was on a ventilator and was continually monitored by a system of alarms to alert NICU staff to any abnormal changes in the infant's blood pressure, heart rate, or oxygen saturation levels. Three physicians were present and on duty in the NICU.

After the infant was repositioned by Ms. Sloan and the infant's nurse, Ms. Sloan suctioned large amounts of secretions from the infant's airway for 15 minutes while the nurse held and manually ventilated the infant. When they listened to the infant's lung sounds again, they heard "wheezing," a not unusual sound associated with an infant's response to suctioning. None of the infant's alarms went off, nor did the nurse observe any symptoms indicating that the infant had a life-threatening emergency. While the nurse remained with the infant, Ms. Sloan left the infant's bedside, and returned with a container of Levalbuterol, a bronchodilating medication that requires a physician's order before administration. The medication is ordinarily administered to NICU infants in aerosol form for lung inhalation but had never been prescribed for this infant. Ms. Sloan however, administered the Levalbuterol by instillation, squeezing the contents of the vial directly into the infant's endotracheal tube. The infant became immediately unstable with a dramatic increase in her heart rate and a sudden drop in her blood pressure and her bedside alarms sounded. The three NICU physicians arrived within moments to assess the infant's now emergent condition, called the attending supervising neonatologist to seek her advice, and tried to stabilize the infant while discussing possible explanations for the sudden change in her clinical status.

Ms. Sloan did not tell the physicians what she had done, and they were unaware of Ms. Sloan's unauthorized administration of the drug until the nurse informed the senior physician, who

then informed the attending neonatologist. Ms. Sloan asked the neonatologist to not report the incident to the respiratory care supervisor because it could affect her employment. In a contemporaneous written incident report, Ms. Sloan stated that she gave the Levalbuterol one time "in lieu of" normal saline to correct the infant's wheezing. During a subsequent interview with the hospital's director of respiratory care, Ms. Sloan stated that she gave 3 or 4 drops of Levalbuterol followed by normal saline, a statement at odds with the facts in her written incident report. In a subsequent disciplinary action, the hospital moved to discharge Ms. Sloan for engaging in "conduct detrimental to patient care" but later accepted her letter of resignation.

At the evidentiary hearing on the Board's charges, Ms. Sloan contradicted her claims that there was an emergency and that a physician was unavailable by conceding that she saw two physicians on her way to get the Levalbuterol but did not stop to notify them of an emergency.

The Board also concluded that by administering Levalbuterol without a physician's written or verbal order, Ms. Sloan exceeded her scope of practice as a respiratory care practitioner and practiced medicine without a license, in violation of Md. Code Ann., Health Occ. §14-5A-17(a)(23), § 14-601, and COMAR 10.32.11.05 and 10.32.11.09. The Board expressed its concerns that (1) the drug was not indicated; (2) there was no medical emergency prior to Ms. Sloan's administration of the drug; (3) her administration of Levalbuterol by endotracheal instillation was a medically unsound method of doing so; (4) national clinical guidelines incorporated in the Board's regulations do not permit the administration of Levalbuterol in non-aerosolized form by a respiratory care practitioner even if a patient has an airway emergency; and (5) Ms. Sloan's voluntary decision to undertake solo intervention herself resulted in a life-threatening situation that subjected this already critically-ill newborn to further medical destabilization and potential catastrophe.

The Board further concluded that Ms. Sloan engaged in unprofessional conduct in the practice of respiratory care, in violation of Md. Code Ann., Health Occ. § 14-5A-17(a)(3), by: (1) failing to promptly inform the responding physician staff of her administration of the drug as they tried to stabilize the infant and ascertain the cause of the abrupt change in the infant's condition, and by depriving the physicians of clinically vital information at the time they urgently needed it; and (2) trying to prevent the reporting of her conduct, and giving inconsistent explanations for her conduct. *Id.*, Health Occ. § 14-5A-17(a)(3). The Board found that Ms. Sloan's unlawful actions were inimical to the NICU team approach necessary for appropriate medical assessment and patient care. In addition, the Board was equally disturbed by Ms. Sloan's request that the neonatologist not report Ms. Sloan's unauthorized administration of the medication to her supervisor. The Board found that Ms. Sloan not only behaved unethically but failed to take responsibility for her actions.

The Board suspended Ms. Sloan's respiratory care license for six months and placed her on probation for a minimum of three years with terms and conditions, one of which required her to enroll in and successfully complete, at her own expense, a Board-approved ethics course within one year. Ms. Sloan was required to submit to the Board written documentation regarding the particular course she proposed to fulfill this condition, and to submit written documentation to the Board after her successful completion of the course. She did not do so.

Ethics Course: Events Between August, 2005 - May, 2007

Ms. Sloan appealed the Board's August 19, 2005 Final Decision and Order in the Circuit Court for Baltimore County.[2] Case No. 03-C-05-9984. On August 25, 2006, Ms. Sloan sent a letter

[2] Ms. Sloan requested reversal of the Board's decision, including the condition requiring her to complete an ethics course. On March 18, 2008, the circuit court affirmed the Board's decision.

to the Board entitled "Petition for Suspension Lifting." In September 2006, Board staff discussed the letter with Ms. Sloan and requested documentation of her completion of the ethics course. Ms. Sloan claimed that she was not aware of the requirement to take an ethics course. In correspondence with the Board, Ms. Sloan requested that the Board extend the deadline for her completion of the ethics course, terminate her suspension, and reinstate her license.

Throughout October 2006, Board staff worked with Ms. Sloan by giving her the necessary contact information for an ethics tutor to facilitate her enrollment in the ethics course. On October 12, 2006, Ms. Sloan submitted an application for reinstatement of her license and on October 17, 2006, she filed a Petition for the Termination of Suspension through counsel. In November 2006, Ms. Sloan met with the ethics tutor, enrolled in the course and made the first of four installment payments. She later discussed with him his expectations for the course's requirement of a paper. In December 2006, the ethics tutor emailed Ms. Sloan and explained that it would be a good idea for her to meet with him to discuss the direction of her paper before she began a first draft. In February 2007, the ethics tutor informed Board staff that Ms. Sloan had not made any of the remaining payments for the course and that she needed to pay the fees before continuing the course and in July, 2007, notified the Board's probation analyst that he had not heard from Ms. Sloan for a while.

May 23, 2007 Order Terminating Suspension/Order of Probation

On May 23, 2007, following a review of Ms. Sloan's application for reinstatement of her respiratory care practitioner license, the Board approved her application and terminated her suspension in an Order Terminating Suspension/Order of Probation. The Board placed Ms. Sloan on probation for a minimum of three years with terms and conditions, and gave her an additional six months until November 23, 2007, to complete the ethics course, a date that was more than

fifteen months after the original date that had been set for completion of the course. The Order also provided that if Ms. Sloan failed to comply with the terms and conditions of probation, that "the Board may impose any disciplinary sanction it deems appropriate." Completion of the ethics course was one of the terms of probation set out in the Order of May 23, 2007. The Board sent Ms. Sloan a copy of the May 23, 2007 Order, and notified Ms. Sloan and her counsel on three occasions that she was required to comply with the conditions of probation.

August 5, 2008 Violation of Terms of May 23, 2007 Order Terminating Suspension/Order of Probation

On March 26, 2008, after reviewing the investigative information and learning that Ms. Sloan had not yet completed the required ethics course, the Board voted to charge her with violating the terms of the May 23, 2007 Order and issued formal charges on August 5, 2008. Ms. Sloan was notified of the charges and appeared at a case resolution conference. The case did not settle and was referred to OAH. After Ms. Sloan failed to appear at the subsequent pre-hearing conference, the Administrative Law Judge issued a Proposed Default Order on December 11, 2008, and Ms. Sloan was notified of her right to file exceptions with the Board within fifteen days. No exceptions were filed.

March 27, 2009 Final Decision and Order

On March 27, 2009, the Board issued a Final Decision and Order revoking Ms. Sloan's license. In determining that revocation was the appropriate sanction, the Board considered Ms. Sloan's disciplinary history and her serious offense of endangering the life of an infant under her care in the NICU. The Board further considered her attempt to hide what she had done, her violation of the boundaries of her professional practice, and her awareness of those boundaries when she violated them. The Board concluded that Ms. Sloan's original offense demonstrated her unwillingness or inability to comply with her professional obligations, and that her conduct since

her reinstatement in May 2007 confirmed the Board's view that this problem had continued. Ms. Sloan was given a second chance to fulfill her obligations and to become knowledgeable in the critical area of ethics, an area in which she had a demonstrated weakness. In the Board's view, her refusal or failure to do so could no longer be excused.

APPLICATION FOR REINSTATEMENT

On October 9, 2020, the Board received Ms. Sloan's application for the reinstatement of her license after revocation. According to Ms. Sloan, she was surprised and confused when she checked the Board's website to find her license had been revoked in 2009 because her license had expired for non-renewal in 2008, the Administrative Law Judge's ruling occurred five years before 2009, and she had not worked in the field since 2003. Ms. Sloan also stated that she was seeking reinstatement because "I miss my babies." She further stated that she missed her work and "saw an opportunity to work with [her] babies again." On December 16, 2020, Board staff sent Ms. Sloan a letter advising her of the post-disciplinary reinstatement process and requesting answers to certain questions including the following:

1. In your responses to Character and Fitness Questions 12(b) and (c) on your reinstatement application, you stated that you were confused as to why your license was revoked. Please explain your understanding of the nature and circumstances of your conduct that led to the 2009 revocation of your Maryland license, to include why you failed to take the Board-ordered ethics course?

2. What is your understanding of the Board's concerns with respect to your conduct?

3. Have you accepted responsibility for the action(s) resulting in the revocation of your license?

4. What steps have you taken to lessen the likelihood of recurrence?

5. What efforts have you made to maintain your competency to practice in your area of specialty (i.e. continuing education credits)?

The Board also asked Ms. Sloan about her employment while her license was revoked and her employment prospects if her license was reinstated. On December 22, 2020, the Board received Ms. Sloan's written response. Regarding Question I, Ms. Sloan stated that the first time she heard that her license was revoked was in 2020 when she began looking into getting her license reinstated. She stated she did not understand the 2009 revocation as the Final Decision and Order was issued in 2005, she let her license expire in 2008, and had left the field completely six years earlier. Ms. Sloan added that since she was no longer practicing, she did not notice that her license was under investigation. She further stated that the Board's last address for her was not accurate. A review of the Board's records, however, reveals that Board staff spoke with Ms. Sloan on September 12, 2008 and verified her address at that time. Board staff also confirmed with Ms. Sloan that she received the formal charging document issued on August 5, 2008, in which she was notified of her violation of the May 23, 2007 Order, and the opportunity to attend a Case Resolution Conference scheduled at the Board on October 1, 2008. That same charging document notified her of an evidentiary hearing scheduled at OAH on January 14, 2009. Ms. Sloan informed Board staff that she would be attending the October I, 2008 Case Resolution Conference, and appeared at the Conference in an attempt to settle the case.[3]

Regarding Question 2, Ms. Sloan stated that the Board's concerns were based on her "acting outside her scope of practice. . ." and concerns "that if a similar situation arose that [she] would intervene without waiting for the person to arrive with whom ordering medications is within their scope of practice." In her response to Question 3, Ms. Sloan stated that she had accepted

[3] As set forth on page 6 of this Order, the case did not settle and was referred to OAH. Ms. Sloan failed to appear at a subsequent pre-hearing conference in her case at OAH, and the Administrative Law Judge issued a Default Order on December 11, 2008. Ms. Sloan was notified of her right to file exceptions with the Board within fifteen days but did not respond or file exceptions.

responsibility for her actions and understood that her license was revoked because she "administered a respiratory medication without a medical order." With respect to steps she had taken to lessen the likelihood of reoccurrence, Ms. Sloan claimed that she now understood her role and the roles of others on her team, had matured in the past 18 years, and would wait for an appropriate team member to make the medical decisions. In terms of her competence, she stated that she had passed the credentialing exam required by Board regulations and completed 16 hours of continuing education courses. Ms. Sloan also informed the Board of her employment in the fields of real estate, site acquisition, and life and health insurance since 2002. She stated that she did not have any prospective employment opportunities lined up but would like to work with colleagues and a medical team if her license was reinstated.

CONSIDERATION OF APPLICATION

The reinstatement of an individual's license after revocation is a discretionary decision by a disciplinary panel. Health Occ. § 14-409; *see Oltman v. Maryland State Board of Physicians*, 182 Md. App. 65, 78 (2008). The Panel must consider whether post-disciplinary reinstatement is in the interest of the health and welfare of the general public and consistent with the best interest of the profession. COMAR 10.32.02.06B(7). If a disciplinary panel chooses not to reinstate the petitioner's license, the "disciplinary panel decision denying reinstatement may set out when, *if ever*, a subsequent petition may be submitted." COMAR 10.32.02.06B(8) (emphasis added).

Ms. Sloan has a lengthy disciplinary history with the Board. The conduct that led to the suspension of her license in 2005 and its ultimate revocation in 2009 was extremely serious. As a result of her administration of a non-prescribed and non-indicated drug, she exposed an already gravely-ill newborn in her care to potential medical calamity. Her failure to promptly inform the NICU physician staff of her actions and provide timely clinically essential information, her

inconsistent explanations for her actions, and her attempt to prevent reporting of her conduct, are even more concerning. For those reasons, the Board correctly determined that Ms. Sloan's professional and ethical weaknesses required her completion of a Board-approved ethics course. Ms. Sloan flouted the Board's authority and failed to complete that critical requirement in 2006, 2007 and 2008, despite the Board's efforts to facilitate her compliance, its forbearance in granting her another extension of time to fulfill that legal obligation, and its leniency in reinstating her license in 2007.

Based on the Board's record of events following Ms. Sloan's 2005 suspension, her knowledge of the formal charges issued on August 5, 2008 for her failure to complete the ethics course, and her appearance at the Case Resolution Conference in October, 2008, her claim that she did not know or understand why she was revoked is implausible.[4] In her written responses to the Board's questions in her reinstatement application on December 22, 2020, Ms. Sloan contended that she had accepted responsibility for her actions. That is not, in the Panel's opinion, a sincere or accurate statement. Notably, Ms. Sloan ignored altogether the specific question asking why she failed to take the Board-ordered ethics course. Her answer to the same question at her meeting with the disciplinary panel on March 10, 2021, was that she left the respiratory care profession and went into real estate in 2001. Ms. Sloan's decision to leave the field of respiratory care is irrelevant and did not exempt her from her obligation to timely comply with such a critical requirement in 2006 and 2007 before seeking the privilege of license reinstatement.

[4] Ms. Sloan's license did not expire because of her non-renewal of the license in May, 2008. A license may not lapse by operation of law "while the individual is under investigation or while charges are pending." Health Occ. § 14-403(a); *see also Salerian v. Board of Physicians,* 176 Md. App. 231, 247 (2007). Based on her failure to complete the ethics course required within six months of the May 23, 2007 Order, Ms. Sloan was "under investigation" when the Board voted in March 2008 to charge her with violating the Board's Order. Those charges were "pending" as that term is used in the statute in May, 2008, when her license would otherwise have expired by operation of law. Thus, her license did not lapse or expire and remained active for disciplinary purposes throughout the Board's investigative and charging proceedings.

Ms. Sloan's written and oral communications to the Panel reveal an enduring incapacity or refusal to take responsibility for the medical danger her actions created for the newborn baby in her care and her failure from 2005-2008, to make sustained efforts to address her ethical deficiencies and dishonest behavior. Considering her answers, the Panel is not persuaded that Ms. Sloan appreciates or understands the nature or gravity of her past conduct or that she has gained any meaningful insight into the events that led to her revocation. Nor does the Panel have confidence that the public would be protected if Ms. Sloan were allowed to practice respiratory care. Ms. Sloan's conduct and lengthy disciplinary history undermine the public's trust regarding her fitness to practice respiratory care and harms the integrity of that profession.

Having considered the entire record in this case, including Ms. Sloan's application for reinstatement, Ms. Sloan's responses to questions from the Board, the response from the administrative prosecutor, Ms. Sloan's prior disciplinary orders, and her presentation before the disciplinary panel, Panel A concludes that reinstatement is not within the interests of the health and welfare of the general public and is not consistent with the best interests of the profession. The Panel, therefore, denies Ms. Sloan's application for reinstatement and will not entertain any further applications for reinstatement.

ORDER

It is thus, by Disciplinary Panel A, hereby

ORDERED that the Application for Reinstatement of Respiratory Care Practitioner License of Nina S. Sloan, former license number L03062, is **DENIED**; and it is further

ORDERED that Ms. Sloan shall not reapply for reinstatement of her license to practice respiratory care in Maryland; and it is further

ORDERED that this Order is a public document. *See* Md. Code Ann., Health Occ. §§ 1-607, 14.411.1(b)(2) and Gen. Prov. § 3-333(b)(6).

Signature on file

06/11/2021
Date

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