

Date: 6-12-20

Disciplinary Panel A
Maryland State Board of Physicians
4201 Patterson Avenue, 4th Floor
Baltimore, MD 21215-2299

Re: Surrender of License to Practice Respiratory Care
James Scott Chancey, R.C.P.
License Number: L06190
Case Number: 2219-0103A

Dear Members of Disciplinary Panel A,

Please be advised that, pursuant to Md. Code Ann., Health Occ. ("Health Occ.") § 14-403 (2014 Repl. Vol. & 2019 Supp.), I have decided to **SURRENDER** my license to practice respiratory care in the State of Maryland, License Number L06190, effective immediately. I understand that upon surrender of my license, I may not engage in the practice of respiratory care in the State of Maryland as it is defined in the Maryland Medical Respiratory Care Practitioners Act (the "Act"), Health Occ. §§ 14-5A-01 *et seq.* and other applicable laws. In other words, as of the effective date of this Letter of Surrender, I understand that the surrender of my license means that I am in the same position as an unlicensed individual in the State of Maryland.

I understand that this Letter of Surrender is a **PUBLIC DOCUMENT**, and upon Disciplinary Panel A's ("Panel A") acceptance, becomes a **FINAL ORDER** of Panel A of the Maryland State Board of Physicians (the "Board").

I acknowledge that the Board initiated an investigation of my practice and on February 10, 2020, Panel A issued disciplinary charges against me under Health Occ. § 14-5A-17(a)(3) (is guilty of unprofessional or immoral conduct in the practice of respiratory care), (a)(18) (fails to meet appropriate standards for delivery of respiratory care), and (a)(23) (practices or attempts to practice beyond the authorized scope of practice). Specifically, Panel A alleged that I created and applied an unapproved device to a patient's endotracheal tube to stop an audible cuff leak, but the device likely resulted in harm to the patient. A copy of the charges is attached as Attachment 1. I have decided to surrender my license to practice respiratory care in the State of Maryland to avoid further investigation and prosecution of these disciplinary charges.

I wish to make it clear that I have voluntarily, knowingly and freely chosen to submit this Letter of Surrender to avoid further prosecution of the disciplinary charges. I acknowledge that for all purposes related to licensure, the charges will be treated as if proven.

I understand that by executing this Letter of Surrender I am waiving my right to a hearing to contest the disciplinary charges. In waiving my right to contest the charges, I am also waiving

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Letter of Surrender

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the right to be represented by counsel at the hearing, to confront witnesses, to give testimony, to call witnesses on my own behalf, and all other substantive and procedural protections provided by law, including the right to appeal to circuit court.

I understand that the Board will advise the Federation of State Medical Boards, and the National Practitioner Data Bank of this Letter of Surrender. I also understand that in the event I would apply for licensure in any form in any other state or jurisdiction that this Letter of Surrender may be released or published by the Board to the same extent as a final order that would result from disciplinary action, pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 *et seq.* (2014), and that this Letter of Surrender constitutes a disciplinary action by Panel A.

I further recognize and agree that by submitting this Letter of Surrender, my license will remain surrendered unless and until the Board grants reinstatement. In the event that I apply for reinstatement of my Maryland License, I understand that Panel A or its successor is not required to grant reinstatement; and, if it does grant reinstatement, may impose any terms and conditions the disciplinary panel considers appropriate for public safety and the protection of the integrity and reputation of the profession. I further understand that if I file a petition for reinstatement, I will approach Panel A or its successor in the same position as an individual whose license has been revoked.

I acknowledge that I may not rescind this Letter of Surrender in part or in its entirety for any reason whatsoever. Finally, I wish to make clear that I have been advised of my right to be represented by an attorney of my choice throughout proceedings before Panel A, including the right to consult with an attorney prior to signing this Letter of Surrender. I have knowingly and willfully waived my right to be represented by an attorney before signing this letter surrendering my license to practice medicine in Maryland. I understand both the nature of Panel A's actions and this Letter of Surrender fully. I acknowledge that I understand and comprehend the language, meaning and terms and effect of this Letter of Surrender. I make this decision knowingly and voluntarily.

Sincerely,

Signature on File

James Scott Chancey

NOTARY

STATE OF Florida

CITY/COUNTY OF Clay

I HEREBY CERTIFY that on this 12th day of June, 2020
before me, a Notary Public of the City/County aforesaid, personally appeared James Scott
Chancey, and declared and affirmed under the penalties of perjury that the signing of this Letter
of Surrender was a voluntary act and deed.

AS WITNESS my hand and Notarial seal.



[Signature]
Notary Public

My commission expires: Sept 29 2020

ACCEPTANCE

On behalf of Disciplinary Panel A, on this 24th day of June, 2020,
I, Christine A. Farrelly, accept the **PUBLIC SURRENDER** of James Scott Chancey's license to
practice respiratory care in the State of Maryland.

Signature on File

Christine A. Farrelly, Executive Director
Maryland Board of Physicians [Signature]

Attachment 1

IN THE MATTER OF	*	BEFORE THE
JAMES SCOTT CHANCEY, R.C.P.	*	MARYLAND STATE
Respondent	*	BOARD OF PHYSICIANS
License Number: L06190	*	Case Number: 2219-0103A

**CHARGES UNDER THE MARYLAND
RESPIRATORY CARE PRACTITIONERS ACT**

Disciplinary Panel A (“Panel A”) of the Maryland State Board of Physicians (the “Board”) hereby charges **James Scott Chancey, R.C.P.** (the “Respondent”), **License Number L06190**, under the Maryland Respiratory Care Practitioners Act (the “Act”), Md. Code Ann., Health Occ. (“Health Occ.”) §§ 14-5A-01 *et seq.* (2014 Repl. Vol. & 2019 Supp.). Panel A charges the Respondent under the following provisions of the Act:

§ 14-5A-17. Denials, reprimands, suspensions, and revocations – In general.

(a) *In general.* – Subject to the hearing provisions of § 14-405 of this title, 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:

...

(3) Is guilty of unprofessional or immoral conduct in the practice of respiratory care;

...

(18) Fails to meet appropriate standards for the delivery of respiratory care performed in any inpatient or outpatient facility, office, hospital or related institution, domiciliary care facility, patient’s home, or any other location in this State; [and]

...

(23) Practices or attempts to practice beyond the authorized scope of practice[.]

The pertinent provisions of the Board's regulations in Md. Code Regs. ("COMAR") provide:

10.32.11 Licensing of Respiratory Care Practitioners.

...
.05 Code of Ethics.

A. A respiratory care practitioner shall:

(1) Practice medically acceptable methods of treatment and may not endeavor to practice beyond the competence and the authority vested in the respiratory care practitioner by the physician;

...

(3) Be responsible for the competent and efficient performance of assigned duties;

...

(9) Uphold the dignity and honor of the profession and abide by its ethical principles; [and]

...

(10) Be familiar with existing State and federal laws governing the practice of respiratory care and comply with those laws[.]

B. A breach of the ethical principles stated in § A of this regulation may be considered immoral or unprofessional conduct in the practice of respiratory care. . . .

ALLEGATIONS OF FACT¹

Panel A bases its charges against the Respondent on the following facts that it has cause to believe are true:

¹ The statements of the Respondent's conduct set forth in this document are intended to provide the Respondent with reasonable notice of the alleged facts. 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 the charges.

I. Background

1. At all relevant times, the Respondent has been licensed to practice as a respiratory care practitioner in the State of Maryland. The Respondent was first licensed to practice as a respiratory care practitioner in Maryland on or about March 5, 2014, under License Number L06910. His license is active through May 30, 2020.

2. On or about August 8, 2018, the Board received a Mandated 10-Day Report from a Maryland hospital (the "Hospital")² that reported the Respondent had resigned from the Hospital in lieu of termination on or about August 2, 2018.

3. According to the Mandated 10-Day Report, on or about July 18, 2018, the Respondent manufactured and applied a device to a patient that was "without approval or backing by hospital policy or any known best practice." The Report explained that the Respondent was called to evaluate a patient (the "Patient") with a possible endotracheal tube ("ETT") cuff leak, and, while waiting for the anesthesia team to arrive and replace the ETT, the Respondent "combined a 10 cc syringe, suction adapter, tape and oxygen connective tubing to flow 1 [liter per minute] of continuous oxygen into the pilot balloon of the cuff." The Report then explained that the anesthesia team replaced the Patient's ETT four times, with the first two ETTs having ruptured or blown cuffs upon removal. The anesthesia team, according to the Report, conducted "bench testing" and believed that the device the Respondent made and applied to the ETTs caused the cuffs to rupture inside the Patient's trachea. The Patient was later found to have a large tracheal tear requiring emergency surgical repair.

² To maintain confidentiality, the names of all witnesses, facilities, employees, and patients will not be used in this document but will be provided to the Respondent on request.

II. Board Investigation

4. The Board initiated an investigation into the Respondent's conduct based on the statements in the Mandated 10-Day Report.

5. As part of its investigation, the Board obtained the Respondent's personnel file from the Hospital. The Respondent's personnel file showed that he worked at the Hospital as a respiratory therapist beginning on or about July 28, 2014, and was terminated from his employment there on or about August 2, 2018.³

6. The Respondent's personnel file included a "Corrective Action Form" dated August 2, 2018, that addressed the termination of his employment. A supervisor from the Hospital's Respiratory Care Department ("Supervisor 1") completed the Corrective Action Form. Supervisor 1 described the events leading to the Respondent's termination as follows:

On the morning of July 18, 2018, at 11:00 . . . the [Respondent] was called to room 9 . . . because of an endotracheal tube (ETT) cuff leak. On arrival the therapist noted an audible cuff leak, and proceeded to deflate the cuff and add 40ml of air into the cuff. The cuff pressure was checked and found to be zero mmHG. He then placed additional air into the pilot balloon and capped the end to see if the pilot balloon was leaking. When it was determined that a leak was still present, he constructed a device using a 10ml syringe, suction adapter, and oxygen connecting tubing. He then connected the device to the pilot balloon and introduced a constant 1 liter per minute flow of oxygen into the cuff. Anesthesia responding reports that they were not initially aware the device was being used. The patient had four ETT tube changes and the device was used on the initial and then two subsequent tubes. These three tubes had significantly ruptured cuffs when removed. Significant subcutaneous air was present and on X-ray a massive right sided pneumothorax was noted. After the fourth

³ As stated in Paragraph 2, *supra*, the Mandated 10-Day Report states, and the Respondent maintains, that he was given the opportunity to resign in lieu of termination. Any such resignation letter is not in the Respondent's personnel file that the Hospital provided to the Board.

tube exchange the patient was taken to the OR were interventional radiology performed a bronchoscopy that showed a large 5cm defect in the right posterior trachea.

7. Supervisor 1 concluded that the incident “demonstrates a serious lack of responsibility” and violated multiple Hospital policies. Supervisor 1 also stated that the “decision to construct an unapproved medical device and utilize it in the care of [a] patient is outside the scope of [a] Respiratory Therapist.”⁴

8. On or about October 22, 2018, the Board notified the Respondent by letter about the Hospital’s Mandated 10-Day Report and requested a written response from him.

9. On or about November 4, 2018, the Respondent provided the Board with his written response. The Respondent acknowledged applying an “unapproved device to a patient” in an “emergent situation,” but insisted, among other things, that he “immediately informed the primary physician and physician assistant” as well as the responding anesthesiologist (the “Anesthesiologist”) about the device. The Respondent insisted that the device was initially applied for about 40 minutes, and no other practitioners told him during that time that they “were uncomfortable with [his] actions or disapproved[.]” The Respondent also stated that the cause of the Patient’s trachea damage was “never conclusively determined.”

10. On or about March 29, 2019, Board staff interviewed Supervisor 1 under oath. Supervisor 1 confirmed and reiterated the description of the device the Respondent made and used that Supervisor 1 provided in the August 2, 2018 Corrective Action Form

⁴ Previously, in a Performance Review completed September 2, 2016, under a section titled “Communication,” another supervisor wrote that the Respondent “does not always stick to the constructed plan that was agreed upon during rounds. Moreover, this deviation from the plan is not consistently relayed to the ICU team . . . A physician had expressed her concerns about [the Respondent] not communicating and doing his own thing.”

(see ¶ 6, above). Supervisor 1 explained that, in his 33 years of experience as a respiratory care practitioner, he had never seen a device like the one the Respondent made and applied to the Patient. According to Supervisor 1, the Respondent should have “removed the [P]atient from the ventilator and manually . . . with a resuscitation bag [and] just bagged . . . the [P]atient until the physician would’ve had time to get there and to . . . put in another ET tube.” Supervisor 1 also stated that making a device such as the one the Respondent made and applying it to a patient was not within the scope of practice for a respiratory care practitioner.

11. On or about March 29, 2019, Board staff interviewed the Director of the Hospital’s Respiratory Care Department (“Supervisor 2”) under oath. Supervisor 2 confirmed and reiterated the description of the device the Respondent made and used that Supervisor 2 included in the Mandated 10-Day Report (see ¶ 3, above). Supervisor 2 explained that, in his experience as a respiratory care practitioner, he had never seen a device like the one the Respondent made. According to Supervisor 2, the Respondent should have worked with a physician team to exchange the airway, or, as a last resort, “pull the tube out and manually ventilate them at the face[.]” Supervisor 2 said that he believed the Respondent “was proud of the fact that he would operate at the fringes of safe practice.”

12. On or about May 16, 2019, Board staff interviewed the Anesthesiologist under oath. The Anesthesiologist explained the following information, among other things, during his interview:

- a. He was called to the Patient’s room to evaluate an ETT cuff leak. Upon arrival in the room, the Respondent was in the room at the head of the Patient’s bed and told the Anesthesiologist that there was a continuous ETT cuff leak “despite some measures that [the Respondent] took.” They did not

discuss what the Respondent had done, nor did the Respondent indicate that he used a specific device.

- b. The Anesthesiologist heard a cuff leak and began the process to replace the first ETT. After removing the first ETT and placing the second ETT, he noticed that the first ETT cuff was “ripped into threads,” which he said was “extremely unusual.”
- c. While the Anesthesiologist was evaluating the damage to the first ETT on the side of the bed, he heard “a pop” in the room.
- d. After determining the second ETT was also leaking, the Anesthesiologist replaced the second ETT with a third ETT. The second ETT cuff was also torn in a similar way to the first ETT cuff.
- e. The Anesthesiologist replaced the third ETT with a fourth ETT after again noticing a cuff leak. Around that time, he and his team noticed “some kind of makeshift assembly device next to the bed,” which the Respondent had constructed. They had not seen the device before because it “was either behind [the anesthesia team] or it was on the ventilator, but it was not in the normal view of [the Anesthesiologist].”
- f. When the Anesthesiologist removed the third ETT, he saw that the cuff was intact. He and his team “replicated what [the Respondent] did on the first two [ETTs] . . . on the third [ETT], and we watched in front of our eyes how the cuff . . . expanded in size and then ruptured.” The Respondent looked “shocked and horrified” at the result of his device being applied to the ETT.
- g. The Anesthesiologist believed that the Respondent’s device provided too much flow into the Patient’s ETT cuff “and ended up blowing up the balloon . . . inside [the Patient].” He called for a team of trauma surgeons to evaluate the Patient. While using a camera to assist in the insertion of another ETT, the surgeons and the Anesthesiologist noted a 10cm injury to the trachea “from right below the vocal cords all the way down to where it splits to the carina.” The Anesthesiologist further stated that there was “no other reason why [the Patient] would have incurred [the tracheal injury] if not for the connection of [the Respondent’s] device to that ETT cuff.”
- h. The Anesthesiologist had never seen a device such as the one the Respondent made used on any patient in his over 14 years of medical practice.

- i. The Anesthesiologist, among others, submitted an article for publication in which he and the other authors discussed the Patient's case as well as the results of the Respondent's creating and applying an unapproved medical device to the Patient's ETT.⁵

13. On or about July 9, 2019, Board staff interviewed the Respondent under oath. The Respondent said that when he evaluated the Patient's ETT on or about July 18, 2018, he determined there was a cuff leak and he attempted to infuse air into the cuff through the pilot balloon. He felt no resistance in the balloon and the cuff pressure "registered zero." The Respondent said he was also being called to another room and, as a result, was back-and-forth between the other room and the Patient's room. While waiting for the anesthesia team to arrive, he "improvised a line from the [oxygen] source and put about a half a liter flow into the [Patient's ETT] pilot balloon." He checked on the Patient for the next 15-20 minutes and "everything seemed fine." The Respondent asserted that he told the anesthesia team about his device as soon as they arrived. The anesthesia team replaced the Patient's ETT, but they could not get any pressure on the ETT cuff, so, according to the Respondent, he asked the Anesthesiologist if it was "okay to hook back up" the device he had made. He was unsure if anyone assented to his reconnecting the device, but he did so anyway.

⁵ On or about September 15, 2019, the article was published in a peer-reviewed journal. The article included a description of the case that was consistent with what the Anesthesiologist described during his interview with the Board. The article also noted that the Patient had a stable oxygen saturation and adequate expiratory tidal volumes with the first ETT, even with the cuff leak and prior to placement of the Respondent's device. The article explained the authors' concern about "a large iatrogenic tracheal injury" once they observed an intact ETT cuff explode within 50 seconds when connected to the Respondent's device. The article also observed that "without a pressure-release mechanism or a 3-way connection to monitor cuff pressure, an intact ETT cuff insufflated at 1 [liter per minute] will expand quickly, dilate the trachea, and then explode, causing a blast injury strong enough to rupture the trachea." The article's authors ultimately concluded that "ETT exchange was the safest and most appropriate option considering the patient's sufficient [tidal volumes] and stable vital signs initially."

14. The Respondent acknowledged during the interview that the “standard procedure” would have been to “pull and ET tube and bag mask” if there was trouble ventilating and the anesthesia team was not present to replace the ETT. The Respondent also acknowledged that he had operated outside the scope of practice for a respiratory care practitioner by creating and applying the device to the Patient.

15. On or about July 31, 2019, the Board requested a peer review of the Respondent’s actions from a Professor of Respiratory Therapy at a Maryland college, who is also licensed by the Board to practice as a respiratory care practitioner in Maryland (the “Peer Reviewer”).⁶

16. On or about August 26, 2019, the Peer Reviewer provided the Board with his report. The Peer Reviewer explained that the standard of care when presented with a patient with a compromised ETT is to “extubate the patient and manually ventilate the patient with 100% oxygen via a bag/mask device until anesthesia arrived to assist with the airway.” The Peer Reviewer also stated that the scope of practice for a respiratory care practitioner “does not provide for designing and/or applying unapproved medical devices[.]” Accordingly, the Peer Reviewer concluded that the Respondent:

- Failed to meet appropriate standards for the delivery of respiratory care performed in the State of Maryland;
- Practiced or attempted to practice beyond the authorized scope of practice for a respiratory care practitioner; and
- Is guilty of unprofessional or immoral conduct in the practice of respiratory care.

⁶ Specifically, the Board requested that the Peer Reviewer review case records provide an opinion about whether the Respondent violated any provisions of Health Occ. § 14-5A-17(a).

III. Grounds for Discipline

17. The Respondent's conduct described above constitutes, in whole or in part, unprofessional and/or immoral conduct in the practice of respiratory care, in violation of Health Occ. § 14-5A-17(a)(3).

18. The Respondent's conduct described above constitutes, in whole or in part, failure to meet the appropriate standards for the delivery of respiratory care performed in a hospital in the State, in violation of Health Occ. § 14-5A-17(a)(18).

19. The Respondent's conduct described above constitutes, in whole or in part, the practice or attempt to practice beyond the authorized scope of practice for a respiratory care practitioner, in violation of Health Occ. § 14-5A-17(a)(23).

NOTICE OF POSSIBLE SANCTIONS

If, after a hearing, a disciplinary panel of the Board finds that there are grounds for action under Health Occ. § 14-5A-17(a)(3), (18), and/or (23), it may impose disciplinary sanctions against the Respondent's license in accordance with the Board's regulations under COMAR 10.32.11.15 and 10.32.11.16, including revocation, suspension, reprimand, and may place the Respondent on probation. The panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent.

NOTICE OF DISCIPLINARY COMMITTEE FOR CASE RESOLUTION CONFERENCE, PREHEARING CONFERENCE AND HEARING

A Disciplinary Committee for Case Resolution ("DCCR") Conference in this matter, is scheduled for **Wednesday, April 8, 2020, at 9:00 a.m.**, at the Board's office, 4201 Patterson Avenue, Baltimore, Maryland 21215. The nature and purpose of the DCCR is described in the attached letter to the Respondent. The Respondent must confirm in

writing his intent to attend the DCCR. The Respondent should send written confirmation of his intent to participate in the DCCR to:

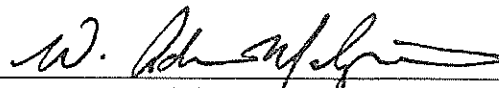
Christine A. Farrelly
Executive Director
Maryland State Board of Physicians
4201 Patterson Avenue, 4th Floor
Baltimore, Maryland 21215

If the case cannot be resolved at the DCCR, a pre-hearing conference and a hearing in this matter will be scheduled at the Office of Administrative Hearings, 11101 Gilroy Road, Hunt Valley, Maryland 21031. The hearing will be conducted in accordance with Md. Code Ann., Health Occ. § 14-405 and Md. Code Ann., State Gov't §§ 10-201 *et seq.* (2014 Repl. Vol. & 2019 Supp.).

BRIAN E. FROSH
Attorney General of Maryland

February 10, 2020

Date



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