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| **IN THE MATTER OF** | * | **BEFORE THE** |
| **MICHELLE FARR, Radiographer** | * | **MARYLAND STATE** |
| **Respondent** | * | **BOARD OF PHYSICIANS** |
| **License Number: R04959** | * | **Case Number: 2218-0295** |

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## CONSENT ORDER

On March 4, 2020, Disciplinary Panel A ("Panel A") of Maryland State Board of Physicians (the "Board") charged **MICHELLE FARR**, Radiographer (the "Respondent"), under the Maryland Radiation Therapy, Radiography, Nuclear Medicine Technology, and Radiology Assistance Act (the "Act"), Md. Code Ann., Health Occ. §§ 14-5B-01 *et seq.* (2014 Repl. Vol. & 2019 Supp.). Specifically, the Respondent was charged under the following provisions of Health Occ. § 14-5B-14:

> (a) 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 deny a license to any applicant, reprimand any licensee, place any licensee on probation, or suspend or revoke a license, if the applicant or licensee:
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> . . .
>
> (3) Is guilty of unprofessional or immoral conduct in the practice of radiography, radiation therapy, nuclear medicine technology, or radiology assistance;
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> . . .
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> (10) Willfully makes or files a false report or record in the practice of radiation therapy, radiography, nuclear medicine technology, or radiology assistance;
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> . . .

(14) Knowingly makes a misrepresentation while practicing radiation therapy, radiography, nuclear medicine technology, or radiology assistance;

...

(18) Fails to meet appropriate standards for the delivery of quality radiation therapy, radiography, nuclear medicine technology, or radiology assistance care performed in any outpatient surgical facility, office, hospital or related institution, or any other location in this State[.]

On June 10, 2020, Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, Order and Consent.

## FINDINGS OF FACT

Panel A finds the following:

### I. Background

1. At all times relevant, the Respondent has been licensed to practice as a radiographer in the State of Maryland. The Respondent was initially licensed to practice radiography in Maryland on October 1, 1997, under License Number R04959. Her license is presently active and expires on April 30, 2021.
2. The Respondent is also licensed in the State of Virginia.
3. At all times relevant to these charges, the Respondent was employed as a multi-skilled technologist at a hospital (the "Hospital") in Saint Mary's County,

Maryland.[1] The Respondent is currently employed at a radiology facility in the State of Maryland.

4. On or about June 19, 2018, the Board received a Mandated 10-day Report[2] (the "Report") from the Hospital. The Report states that the Hospital terminated the Respondent's employment on April 30, 2018 as a result of an incident wherein the Respondent conducted a CT[3] scan on the wrong patient. The Report states that the Respondent failed to follow Hospital policy on patient identification and hand-off communication and failed to follow proper pregnancy status procedure. In addition, after discovering the error, the Respondent placed an order for the diagnostic test under the name of the assigned nurse practitioner without their authorization.

5. Based on the Report, the Board initiated an investigation of the Respondent.

## II. Board Investigation

6. On or about June 25, 2018, Board staff subpoenaed the Respondent's personnel file from the Hospital.

7. On or about July 19, 2018, Board staff informed the Respondent of the investigation and requested a written response to the allegations.

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[1] To ensure confidentiality and privacy, the names of individuals and entities involved in this case, other than the Respondent, are not disclosed in this document.

[2] Health Occ. §§14-5B-15 requires that within 10 days of an action hospitals report any action taken against a licensee which limits, reduces, otherwise changes, or terminates any licensee for any reason that might be grounds for disciplinary action under provisions of Health Occ. § 14-5B-14 as determined by the Board.

[3] Computed Tomography ("CT") is a radiographic technique that produces an image of a detailed cross-section of tissue. (*Mosby's Medical Dictionary, 10th Ed., 2017.)*

8. On or about July 6, 2018, Board staff received the Respondent's personnel file from the Hospital.

9. On or about August 3, 2018, Board staff received the Respondent's written response.

10. Between approximately October 2018 and May 2019, Board staff conducted interviews with multiple witnesses who are former colleagues of the Respondent, in addition to interviewing the Respondent herself. Board staff also subpoenaed four patient medical records from the Hospital.

11. On or about April 3, 2019, Board staff sent the Respondent a subpoena to appear for an interview. On April 17, 2019, the Respondent was interviewed by Board staff.

12. The Respondent stated that during the incident which prompted the Report, she was working in the CT department and decided to help with transporting patients. She stated that she saw one of the transporters (the "Transporter") with a patient (the "Patient") on their way to get a sonogram[4] when the Respondent stated to the Transporter, "if that's bed twenty, I need that patient." The Transporter subsequently delivered the Patient to the CT suite and placed the Patient on the table. At this point the Respondent looked at her information sheet but did not take it with her into the scan room, then asked the Patient her name. The Patient, a Spanish speaker, then responded with a different name. The

[4] A sonogram is a record, image, or display obtained by ultrasonic scanning. (*Mosby's Medical Dictionary, 10th Ed. 2017.)*

Respondent stated that she believed that she had simply mispronounced the Patient's name and that the Patient was responding with the correct pronunciation. The Respondent noted that the Patient's date of birth was in November as she recalled from the information sheet. The Respondent stated that she frequently gets people's names wrong, and that she doesn't know why she didn't check her information sheet to confirm the name. The Respondent then asked the Patient where her pain was and then conducted the CT scan.

13. The Respondent further stated that after the scan was complete she said to the Transporter "Ok, bed twenty is ready to go back," to which the Transporter responded, "that's not bed twenty." The Respondent then confirmed that she had in fact scanned the wrong patient and then began making calls to notify her supervisors of the incident. The Respondent stated that she called the Patient's doctor, then called the imaging administrator (the "Imaging Administrator") to determine what corrective steps needed to be taken. The Respondent stated that the images that were scanned could not be deleted so there had to be an order placed for them so that they could continue to scan the correct patient ("Patient 2"). At this point the Respondent called the nurse practitioner (the "Nurse Practitioner") to report what had just happened and to ask her to place an order for the images. The Nurse Practitioner declined to do so, so the Respondent placed the order which showed up under the Nurse Practitioner's name.

14. On or about May 8, 2019, Board staff conducted an interview with the Imaging Administrator. The Imaging Administrator stated that he was notified of the

incident while the Patient was still on the table in the CT suite, so he reported to that location to help resolve the situation. The Imaging Administrator confirmed that he instructed the Respondent that an order had to be placed for the incorrect scan so that they could scan the correct patient.

15. On or about November 1, 2018, Board staff conducted an interview with the Transporter. During Board staff's interview with the Transporter, she stated that as she was transporting the Patient, she entered the emergency room and was stopped by the Respondent who stated, "I need her in CT." The Transporter stated that after a brief conversation she complied and moved the Patient to the CT suite to be scanned. Following the scan, the Transporter stated that the Respondent said that she may have just made a mistake. The Transporter stated that after the Respondent confirmed that she had just scanned the wrong patient the Respondent stated "well, I've just lost my job."

16. On or about August 27, 2019, Board staff sent the case file for expert review by a licensed Radiographer. On September 19, 2019, the Board received the expert report. The reviewer opined that the Respondent: committed unprofessional or immoral conduct in the practice of radiography, willfully made or filed a false report in the practice of radiography and failed to meet the standard of quality care by not following hospital policy regarding properly identifying patients prior to performing a scan and placing an order for a scan of the wrong Patient in another person's name without their permission.

## CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Disciplinary Panel A of the Board concludes as a matter of law that the Respondent failed to meet the appropriate standards for the delivery of quality radiation therapy, radiography, nuclear medicine technology, or radiological assistance care performed in any outpatient surgical facility, office, hospital or related institution, or any other location in this State, in violation of Health Occ. § 14-5B-14(a)(18). Panel A dismisses the charges under Health Occ. § 14-5B-14(a)(3), (10), and (14).

## ORDER

It is, thus, on the affirmative vote of a majority of the quorum of Board Disciplinary Panel A, hereby

**ORDERED** that the Respondent is **REPRIMANDED**; 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).

***Signature on File***

07/13/2020
Date

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

**CONSENT**

I, Michelle Farr, Radiographer, acknowledge that I have consulted with counsel before signing this document.

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.

I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 14-405 and Md. Code Ann., State Gov't §§ I0-201 *et seq.* concerning the pending charges. I waive this right and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive protections. I acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order. I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.

I sign this Consent Order, without reservation, and fully understand the language and meaning of its terms.

***Signature on File***

7-1-2020

Date

Michelle Farr, Radiographer

## NOTARY

**STATE OF:** Maryland

**CITY/COUNTY OF:** St Marys

**I HEREBY CERTIFY** that on this 1st day of July, 2020, before me, a Notary Public of the State and City/County aforesaid, personally appeared Michelle Farr, Radiographer, and made oath in due form of law that the foregoing Consent Order was her voluntary act and deed.

**AS WITNESS**, my hand and Notary Seal.

Notary Public

My commission expires:

07/13/2021