IN THE MATTER OF	*	**BEFORE THE MARYLAND**
MICHAEL GOLDMAN, M.D.	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D24976	*	**Case Number: 2220-0207**

* *

CONSENT ORDER

PROCEDURAL BACKGROUND

The Maryland Board of Physicians (the "Maryland Board") received information that Michael Goldman, M.D., (the "Respondent") License Number D24976, was disciplined by the Virginia Board of Medicine (the "Virginia Board"). By Order dated December 2, 2019, the Respondent was reprimanded.

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,

The Maryland Board 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) (22). The ground for disciplinary action under H.O. § 14-404(a) is as follows:

> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care 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 the Maryland Board of Physicians, consisting of Procedural Background, Findings of Fact, Conclusions of Law, and Order of reciprocal action.

I. FINDINGS OF FACT

The Board finds the following:

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 June 19, 1980.

2. By Order dated December 2, 2019, the Virginia Board found the Respondent failed to treat Patient A, a 62- year- old male, for pulmonary embolism. A copy of the Virginia Board Order is attached hereto.

II. CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Maryland Board concludes as a matter of law that the disciplinary action taken by the Virginia Board against the Respondent was for an act or acts that would be grounds for disciplinary action under Health Occ. § 14-404(a)(22) had those offenses been committed in this state, and would thus subject him to discipline under Health Occ. §14-404(a)(21).

III. ORDER

It is hereby:

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

ORDERED that this **CONSENT ORDER** is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§4-101 through 4-601 (2014).

Signature on File

03/04/2020
Date

Christine A. Farrelly
Executive Director
Maryland Board of Physicians

CONSENT

I, Michael Goldman, M.D. assert that I am aware of my right to consult with and be represented by counsel in considering this Consent Order and in any proceedings that would otherwise result from the charges currently pending. 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.

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 §§ 10-201 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.

2/27/20
Date

Signature on File

Michael Goldman, M.D.
Respondent

NOTARY

STATE OF DC

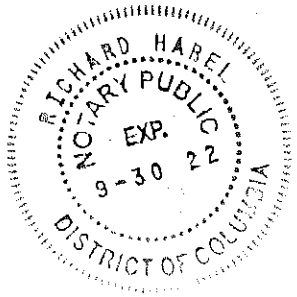
CITY/COUNTY OF WASHINGTON

I HEREBY CERTIFY that on this 27 day of FEB, 2020, before me, a Notary Public of the State and City/County aforesaid, personally appeared Michael Goldman, M.D. and made oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS my hand and notarial seal.

Notary Public

My Commission expires: 9/30/2022



BEFORE THE VIRGINIA BOARD OF MEDICINE

IN RE: **MICHAEL HIAM GOLDMAN, M.D.**
License Number: 0101-043150
Case Number: 184348

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 November 6, 2019, in Henrico County, Virginia, to inquire into evidence that Michael Hiam Goldman, M.D., may have violated certain laws governing the practice of medicine and surgery in the Commonwealth of Virginia.

Michael Hiam Goldman, M.D., appeared at this proceeding and was not represented by legal counsel.

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. Michael Hiam Goldman, M.D., was issued License Number 0101-043150 to practice medicine and surgery on November 1, 1988, which is scheduled to expire on February 29, 2020. At all times relevant to the findings contained herein, said license was current and active.

2. Dr. Goldman violated Virginia Code § 54.1-2915(A)(3) in that he failed to treat Patient A, a 62-year-old male, for a pulmonary embolism. Specifically:

a. Upon referral from Patient A's primary care physician, Dr. Goldman saw Patient A on January 28, 2016 due to abnormal electrocardiogram results and complaints of shortness of breath for approximately a week while engaging in some physical activities, including shoveling snow.

b. Dr. Goldman obtained Patient A's medical history which revealed that he had, among other things, hypertension, hyperlipidemia, and deep vein thrombosis in his lower left extremity (related to a motor vehicle accident in 1992) for which he was treated with Coumadin until 2014. He also had a family history of coronary artery disease. Dr. Goldman conducted a physical examination of Patient A which revealed chronic stasis changes and edema in his left lower extremity. Because Dr. Goldman was concerned that the electrocardiogram results were consistent with ischemia, he performed a cardiac catheterization on Patient A at a hospital. Although the procedure revealed an occluded dominant right coronary artery, Dr. Goldman concluded that Patient A's cardiac disease could be treated on an outpatient basis and cleared him for discharge from the hospital. However, Dr. Goldman ordered additional bloodwork to be taken before discharge, including a D-dimer test due to Patient A's venous stasis and edema in his left lower extremity and prior diagnosis of deep vein thrombosis.

c. Despite the fact that Dr. Goldman was informed later in the evening on the same day, after Patient A's discharge, that Patient A's D-dimer value was 7,605, Dr. Goldman failed to inform Patient A of the D-dimer value or to direct him to return immediately to the hospital. Rather, he dictated a letter to the physician stating, among other things, that the D-dimer value was "markedly elevated" and that "[g]iven his venous disease, the possibility of chronic subclinical emboli is of concern." Furthermore, Dr. Goldman recommended only that Patient A continue current cardiac medications, renew efforts concerning risk factor modification, follow up with his primary care physician the next week, and have a cardiology follow-up on February 2, 2016, with a chest CT to be obtained before the appointment.

d. The next day, January 29, 2016, Dr. Goldman wrote an order for the chest CT, noting "Pulm Emboli protocol" as a special instruction, but again failed to inform Patient A of the D-dimer value or direct him to return to the hospital. Patient A expired on January 29, 2016.

3. In his statements to the Committee, Dr. Goldman denied that Patient A had a pulmonary embolism and stated that is the reason why he did not treat Patient A for a pulmonary embolism.

4. Although the autopsy report from Virginia Pathology and Autopsy Services attributed the cause of Patient A's death to "pulmonary emboli" and noted that "[s]ections of both lungs show multiple pulmonary emboli of segmental and terminal branches of pulmonary artery…[,]" Dr. Goldman told the Committee that the autopsy was incorrect. Dr. Goldman pointed to a letter from Jeffrey S. Nine, M.D., M. Div., from the Yavapai County Medical Examiner's Office in Prescott Valley, Arizona, that stated the autopsy erroneously found that pulmonary embolism was the cause of death.

5. The Committee noted that in Dr. Goldman's initial evaluation, pulmonary embolus was the initial differential diagnosis, and after acute cardiac disease was ruled out by cardiac catheterization, Dr. Goldman ordered a D-dimer to confirm the possibility of emboli. The Committee also noted from the record that Dr. Goldman recognized the D-dimer value to be "markedly elevated" and that he then ordered a pulmonary embolus protocol CT to be performed non-emergently. Despite this concerning evidence, Dr. Goldman told the Committee that he deferred further evaluation to Patient A's primary care physician.

6. Dr. Goldman told the Committee that, in his opinion, the D-dimer value was "meaningless" and noted that his experts supported his plan of care.

7. The Committee determined that Dr. Goldman did not appropriately respond to the extremely high D-dimer.

8. The Committee considered the deposition testimony of Hillary S. Maitland, M.D., M.S., of the University of Virginia regarding the significantly elevated D-dimer as indicative of pulmonary embolus that required an immediate response. The Committee found that a reasonably prudent physician would have determined that the D-dimer results required immediate attention.

9. Dr. Goldman stated that this was a troubling case because Patient A expired but that he did not think he erred in his judgment or care.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Virginia Board of Medicine hereby ORDERS that Michael Hiam Goldman, 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 Deschenes, J.D., M.S.
Deputy Executive Director, Discipline
Virginia Board of Medicine

ENTERED: 12/2/19

NOTICE OF RIGHT TO APPEAL

Pursuant to Virginia Code § 54.1-2400(10), Dr. Goldman may, not later than 5:00 p.m., on January 8, 2020, notify William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that he 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 January 8, 2020, unless a request for a formal administrative hearing is received as described above.