IN THE MATTER OF	*	**BEFORE THE**
MILTON G. YODER, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D30633	*	**Case Number: 2016-1030 A**

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CONSENT ORDER

On September 28, 2017, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **Milton G. Yoder, M.D**. ("Respondent"), License Number D30633, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2014 Repl. Vol. & 2016 Supp.). The pertinent provisions of the Act provide the following:

Health Occ. § 14-404. Denials, reprimands, probations, suspensions, and revocations -- Grounds.

> (a) *In general.* -- 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:
>
> ...
>
> (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; [and]
>
> ...
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

On January 10, 2018, Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring because of the DCCR, Respondent agreed to enter this Consent Order, consisting of Findings of Fact,

Conclusions of Law, and Order.

FINDINGS OF FACT

Panel A makes the following findings of fact:

I. Background

1. At all times relevant hereto, Respondent was and is licensed to practice medicine in the State of Maryland. Respondent was originally licensed to practice medicine in Maryland on April 3, 1984. Respondent last renewed his license in September 2017, which will expire on September 30, 2019.

2. On September 23, 1977, Respondent was granted lifetime board-certification in Otolaryngology.[1]

3. Respondent maintains offices in Lutherville and Fallston, Maryland for the solo practice of otolaryngology. In addition, Respondent employs two audiologists in his practice.

4. Respondent holds privileges at an ambulatory care center in Maryland, an outpatient surgical facility which is accredited by the Accreditation Association for Ambulatory Health Care ("AAAHC").

II. Complaint and Investigation

5. On or about June 16, 2016, the Board received a written "Mandated 10-day Report" [2] (the "Ten-Day Report") from a hospital in Maryland, Hospital A, [3] where

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[1] Otolaryngology is a surgical subspecialty within medicine that deals with conditions of the ear, nose, and throat ("ENT") and related structures of the head and neck.

[2] Pursuant to Health Occ. § 14-413(a) a hospital is required to report to the Board if a licensed physician who has privileges with the hospital has had staff privileges changed, if the change is for reasons that might be grounds for disciplinary action. The hospital shall submit the report within 10 days of the action.

[3] The name of the hospital is not used in this Consent Order. Respondent is aware of the identity of Hospital A.

Respondent held hospital privileges. The Ten-Day Report stated that Respondent's privileges were suspended.

6. Attached to the Ten-Day Report was a copy of correspondence from Hospital A to Respondent, dated June 8, 2016, informing Respondent that his clinical privileges at Hospital A were suspended, which would remain in effect for 14 days unless withdrawn sooner by agreement of the President, Vice President of Medical Affairs and Department Chairman, or a determination was made to extend it. The suspension was based on an initial investigation of a surgical complication regarding Patient 1,[4] which occurred on June 7, 2016 and Respondent's delayed response to that complication.

7. On June 28, 2016, Hospital A informed Respondent that his privileges at Hospital A were terminated, and that his privileges would remain suspended pending final action.

8. On July 27, 2016, the Board provided Respondent with a copy of the Ten-Day Report and requested his response.

9. As part of its investigation, the Board subpoenaed Respondent's medical records of Patient 1, Patient 1's medical records from Hospital A and Hospital B,[5] where Patient 1 had been transferred for follow-up surgical care. The Board also subpoenaed Respondent's Quality Assurance/Risk Management ("QA/RM") file from Hospital A and from another hospital, Hospital C, where Respondent had previously held privileges.

10. On or about March 30, 2017, the Board sent the Ten-Day Report, Respondent's response to the Ten-Day Report, excerpts from Respondent's QA/RM file

[4] The name of the patient is confidential and is not used in this Consent Order. Respondent is aware of the identity of Patient 1.
[5] Respondent is aware of the identity of Hospital B.

from Hospital A to two peer reviewers, both board-certified in otolaryngology, for an independent peer review. In addition, the Board sent Patient 1's medical records as provided by Respondent, Hospital A, and Hospital B. Upon review of the documents, the peer reviewers concurred that Respondent failed to meet appropriate standards of care and failed to maintain adequate medical records regarding Patient 1.

III. Specific Findings Pertaining to Patient 1

11. In April 2007, Respondent began providing care for Patient 1, following the fracture of her nose after a fall. Respondent treated patient periodically in 2009, 2012, and from 2013 to 2016 for chronic sinusitis.

12. Following a CT scan on May 13, 2016, Respondent recommended septal and sinus surgery for Patient 1, then in her mid-sixties.

13. On June 7, 2016, Respondent performed septoplasty (septal reconstruction of the bony septum), excision of left concha bullosa, and endoscopic bilateral maxillary sinus surgery on Patient 1.

14. After the surgery, Respondent packed Patient 1's nose and left the operating room. Before Patient 1 was extubated and awakened, Respondent left Hospital A to see patients in his private office about 25 minutes away.

15. Respondent's surgical technician ("the Surgical Technician") was immediately concerned that Patient 1 had eye swelling. Another ENT surgeon ("Physician A"[6]) became involved and directed the surgical technician to call Respondent and tell him about the swelling.

16. The Surgical Technician called Respondent and informed him about

[6] Respondent has been provided a Confidential Identification List which discloses the identities of Patient 1, each of the facilities, and all the individuals who are referenced in the Consent Order.

inability to extubate Patient 1, decreased responsiveness, unequal pupils, bleeding from nose and mouth, bruising and swelling of left orbit and requested that Respondent come to evaluate Patient 1. Respondent directed that cold compresses be applied to the eye. He was on his way to his office to see patients and he would return in a few hours.

17. Patient 1 was taken to the post anesthesia care unit ("PACU").

18. Respondent was contacted by Physician B, who informed Respondent of the seriousness of the situation and the need for him to return to Hospital A.

19. Physician A assessed Patient 1 with swelling and bruising of the left periorbital tissue, with protrusion of the eyeball and hemorrhaging from her nose. Patient 1 had pin point pupils bilaterally.

20. The Rapid Response Team[7] was called and noted proptosis[8] and that Patient 1's pupils were unequal with the left pupil larger than the right.

21. A Physician Assistant, part of the Rapid Response team (the "Physician Assistant"), called Respondent again regarding the seriousness of the ocular injury. Respondent stated that he was nowhere near the orbit during the surgery, that the bleeding will stop, and that he was in his office.

22. Physician A then called Respondent and explained her findings and her concern for an ocular emergency, based on her findings. Physician A told Respondent that she thought that Patient 1 needed to be evaluated by an ophthalmologist and possibly be transferred to another hospital for specialty care. Respondent stated that the complication was due to the anesthesia and he would not be coming to see Patient 1.

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[7] A rapid response team ("RRT"), is a team of health care providers that responds to hospitalized patients with early signs of deterioration on non-intensive care units to prevent respiratory or cardiac arrest.
[8] Proptosis is abnormal protrusion or displacement of an eye or other body part.

23. Respondent was called by an anesthesiologist, Physician C, who informed Respondent that Patient 1 may die and Respondent needed to return to Hospital A immediately. Respondent stated he could not return, he was busy but he would see what he could do when he finished office hours, in the late morning.

24. Respondent was called by the Division Chief, Physician D, who told Respondent to return to Hospital A to "take ownership of the situation and follow-up immediately." Respondent stated he would comply.

25. Physician A contacted an ophthalmologist at Hospital B.

26. A post-operative CT scan of Patient 1's head and facial bones revealed a fracture to the left orbital wall, which was not present on the pre-operative CT scan and proptosis of the left eyeball.

27. Respondent returned to Hospital A, approximately 2½ hours after Respondent completed Patient 1's surgery.

28. By the time Respondent returned to Hospital A, other physicians had already arranged for Patient 1's transfer to Hospital B, a tertiary care institution.

29. Respondent returned to his private office.

30. Physician E called Respondent and instructed him to call the surgeon at Hospital B to provide "handoff care."

31. An hour and a half after being given the instruction, Respondent had not initiated contact with the accepting surgeon at Hospital B.

32. Physicians at Hospital B diagnosed a retrobulbar hematoma and performed lateral canthotomy and cantholysis (emergent orbital decompression).

33. Three days after the surgery, on June 10, 2016, Respondent documented

in Patient 1's office medical record, post-surgery, "...She bled into her left eye and developed orbital problems..."

34. On June 15, 2016 Respondent documented in Patient 1's medical record: "Both (Patient 1 and her husband) understand that the problem was she had systolic BP (blood pressure) of 200 postop."

35. In his response to the Board regarding the Ten-day Report, Respondent wrote, "In summary, patient's post-operative hypertension cauased (sic) the bleeding."

36. Respondent failed to meet standards for quality medical care in regard to his care and treatment of Patient 1 in that Respondent:

a. Failed to recognize, intra-operatively, that he had violated the orbital wall;

b. Having failed to recognize this known complication of sinus surgery, Respondent failed to initiate treatment of the complication by performing emergency eye procedures such as massaging the globe and requesting that the anesthesiologist give intravenous mannitol to reduce intraocular pressure, or performing a lateral canthotomy and cantholysis, or calling an ophthalmologist;

c. Failed to recognize, post-operatively, when informed telephonically by physicians and staff of Hospital A that Patient 1's physical findings indicated possible bleeding into the orbit from a breach of the orbital wall, that he had violated the orbital wall during surgery;

d. Failed to recognize, post-operatively, when the post-operative CT scan showed there was a violation of the orbital wall with air in the orbit, that he had breached the orbital wall, intra-operatively;

e. Failed to recognize that bleeding into the orbit is an ENT emergency and must be dealt with promptly, to save Patient 1's vision;

f. Failed to return to Hospital A, promptly, to personally evaluate Patient 1, despite numerous requests by physicians and staff of Hospital A, to do so;

g. Failed to recognize, after documentation of increased intra-orbital pressure on the left and after definitive treatment by an

ophthalmologist at Hospital B, that he caused an injury to the orbital wall which was responsible for the complication;

h. Failed to inform Patient 1 that he was responsible for the complication and erroneously informed Patient 1 that her post-operative hypertension was the cause; and

i. Incorrectly attributed Patient 1's symptoms to Patient 1's elevated blood pressure.

37. Respondent failed to keep adequate medical records in regard to his care of Patient 1 in that Respondent:

a. Failed to document physical examinations of Patient 1 at multiple office visits;

b. Failed to document that he discussed the risks of sinus surgery and septoplasty with Patient 1 pre-operatively;

c. Failed to document in his office records that the violation of the left orbital wall occurred during the operation and that Patient 1 experienced a complication after surgery; and failed to document the specific surgical procedures which were performed on Patient 1 at Hospital B on the same day as his operation;

d. Failed to document in his office records that he informed Patient 1 that he inadvertently breached the orbital wall during surgery and the subsequent complication; and

e. Failed to document that Patient 1 had signs of an orbital complication of sinus surgery which required a post-operative CT scan and another ENT operation at Hospital B on the same day as his operation.

IV. Summary of Findings

38. Respondent's failures, as stated above, including but not limited to his failure to recognize during the surgery that he caused an orbital injury, failure to recognize immediately after surgery that the orbital injury was now the cause of the orbital complication and the failure to immediately intervene, is evidence of failure to meet standards for quality medical care, in violation of Health Occ. § 14-404(a)(22).

39. Respondent's leaving the hospital prior to Patient 1 being stabilized and failure to immediately return to the hospital when he had been notified of the emergency is evidence of failure to meet standards for quality medical care, in violation of Health Occ. § 14-404(a)(22).

40. Respondent's failures, as stated above, including but not limited to his failure to accurately document the events pertaining to Patient 1's surgery and the ensuing complication and additional surgery, is evidence of a failure to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40).

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 violated Health Occ. II § 14-404(a)(22) (fails to meet standards of quality of medical care) and Health Occ. II § 14-404(a)(40) (inadequate medical records).

ORDER

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

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

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of **six (6) months**[9]. During the probationary period, the Respondent shall comply with all the following probationary terms and conditions:

1. Within sixty (60) days, the Respondent shall pay a civil fine in the amount of $5,000.00 by money order or bank certified check made payable to the Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297;

[9] If the Respondent's license expires during this six-month period, the six-month period and any conditions will be tolled.

2. Within six (6) months, the Respondent shall successfully complete a Board disciplinary panel-approved in-person course in medical ethics. The course may not be used to fulfill the continuing medical education credits required for license renewal. The Respondent must provide documentation to the Board that the Respondent has successfully completed the course;

3. The Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101 - 14-702, and all laws and regulations governing the practice of medicine in Maryland; and it is further

ORDERED that the Respondent shall not apply for the early termination of probation; and it is further

ORDERED that, after six (6) months if the Respondent has fully and timely complied with the terms and conditions of this Consent Order, and there are no pending complaints related to the charges, the Board or Board Disciplinary Panel A will administratively terminate the probation. The administrative termination of probation will be issued through an order of the Board or Board panel; and it is further

ORDERED that if the Respondent allegedly fails to comply with any term or conditions of probation or this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board or Panel A; and it is further

ORDERED that, after the appropriate hearing, if the Board or Disciplinary Panel determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board or Disciplinary Panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions,

or suspend or revoke the Respondent's license to practice medicine in Maryland. The Board or Disciplinary Panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

ORDERED that the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that, unless stated otherwise in the order, any time prescribed in this order begins when the Consent Order goes into effect. The Consent Order goes into effect upon the signature of the Board's Executive Director, who signs on behalf of the Disciplinary Panel; and it is further

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., Gen. Prov. §§ 4–101 *et seq.*

01/23/2018
Date

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

CONSENT

I, Milton G. Yoder, M.D., License Number D30633, by affixing my signature hereto, acknowledge that:

I am represented by counsel and have consulted with counsel before entering this Consent Order. By this Consent and for the sole purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity 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 own behalf, and to all other

substantive and procedural protections provided by law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

1/17/18
Date

Milton G. Yoder, M.D., Respondent

NOTARY

STATE OF Florida

CITY/COUNTY OF Palm Beach

I HEREBY CERTIFY that on this 17 day of January, 2018 before me, a Notary Public of the State and County aforesaid, personally appeared Milton G. Yoder, M.D., License number D30633, and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Notary Public

My commission expires 07/23/2019

KAREN G BURGESS
Notary Public - State of Florida
Commission # FF 903341
My Comm. Expires Jul 23, 2019
Bonded through National Notary Assn.