IN THE MATTER OF	*	BEFORE THE
HEIN NGUYEN, M.D.	*	MARYLAND STATE
Respondent.	*	BOARD OF PHYSICIANS
License Number D57210	*	Case Number 2015-0632B

* * * * * * * * * * * * *

FINAL DECISION AND ORDER

INTRODUCTION

On January 20, 2016, Hein Nguyen, M.D., a general surgeon, was charged under the Maryland Medical Practice Act ("Act") with professional incompetence, failure to meet appropriate standards for the delivery of quality medical care, and failure to keep adequate medical records. *See* MD. CODE ANN., HEALTH OCC. ("Health Occ.") §§ 14-404(a) (4), (22), (40). The charges concerned two wrong site surgeries performed by Dr. Nguyen.

On May 17, 2016, the case was forwarded to the Office of Administrative Hearings ("OAH") for an evidentiary hearing and a proposed decision. A two-day hearing was held before an Administrative Law Judge ("ALJ") at OAH. At the hearing, the State presented testimony from Jason C. Roland, M.D., who was qualified as an expert in general and minimally invasive surgery. Dr. Nguyen testified on his own behalf and presented testimony from Paul P. Lin, M.D., FACS, who was qualified as an expert in general surgery, and two character witnesses.

On November 21, 2016, the ALJ issued a proposed decision concluding that Dr. Nguyen failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22) and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40).[1] The ALJ did not find that Dr. Nguyen was professionally, physically, or mentally incompetent, in violation of Health Occ. § 14-404(a)(4). Accordingly, the ALJ

[1] In this decision, standards for the delivery of quality medical care and standard of care are used interchangeably.

proposed that the charges for failure to meet appropriate standards for the delivery of quality medical care and failure to keep adequate medical records be upheld and recommended the charge for professional, physical, or mental incompetence be dismissed. The ALJ recommended that the Board reprimand Dr. Nguyen and require him to take a course in medical record keeping if the Board did not feel that the coursework he already completed was sufficient.

On December 13, 2016, the State filed exceptions to the ALJ's proposed decision, and Dr. Nguyen filed a response to the State's exceptions. On March 8, 2017, both parties appeared before Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians ("Board") for an oral exceptions hearing.

FINDINGS OF FACT

Panel A adopts the ALJ's proposed findings of fact 1 - 95. *See* ALJ proposed decision, attached as **Exhibit 1**. These facts are incorporated by reference into the body of this document as if set forth in full. Neither party filed exceptions to any of the factual findings and the factual findings were proved by a preponderance of the evidence. The Panel also adopts the ALJ's discussion set forth on pages 19-45.

This case concerns two surgeries performed by Dr. Nguyen at a Maryland Hospital. The first surgery was performed on January 9, 2015. On the day of the surgery, Dr. Nguyen met with Patient A, obtained informed consent from Patient A for a right inguinal hernia repair with mesh, and marked the patient's right side with a pen to designate that she was scheduled for surgery on her right side. The patient was then brought into the operating room. Dr. Nguyen testified that he observed a bulge on the patient's left side and prepped the left side of the patient for surgery. Before the surgery began, two time-outs were called and in each time-out the procedure was announced as a right-side inguinal hernia repair. Dr. Nguyen, however, completed the surgery

for the left inguinal hernia repair, instead of the right side, as scheduled. Dr. Nguyen did not document a bulge on the left side or any other indication necessitating performing a hernia repair on the left side.

Following the surgery, the patient was transferred to the recovery room and Dr. Nguyen went to transcribe his operating note. At that time, Dr. Nguyen realized that he had performed the surgery on the wrong side. Dr. Nguyen alerted the hospital staff, informed the patient's family, and told the patient what had happened when she awoke from the anesthesia. Thereafter, the patient elected to have Dr. Nguyen proceed with the right inguinal hernia repair. Later the same day, Dr. Nguyen performed the surgery on the right side and successfully repaired the hernia.

The second patient, Patient B, was referred to Dr. Nguyen by a urologist for a right adrenal mass and a thyroid nodule in the right lobe of the thyroid. Patient B was scheduled for surgery on January 28, 2015. Dr. Nguyen met with the patient prior to the surgery and obtained informed consent for the right thyroid lobectomy and adrenalectomy. He did not obtain informed consent for the removal of Patient B's kidney or any other organ. Dr. Nguyen first performed the right thyroid lobectomy and took a frozen section for pathology analysis. The pathology report came back negative for cancer, so Dr. Nguyen left the remainder of the thyroid gland intact and proceeded to perform the adrenalectomy.

During the adrenalectomy, Dr. Nguyen encountered a six-inch abdominal wall of fat, which contained the adrenal gland, adrenal mass, and the kidney. Dr. Nguyen attempted to separate the kidney from the adrenal gland, but was unable to do so because the tissues were stuck together. Dr. Nguyen then inserted a GelPort, which allowed him to put his hand into the abdominal cavity, and, again, tried to separate the mass from the kidney. Dr. Nguyen felt what he

thought was the adrenal gland, but he was unable to dissect the mass from the kidney. Due to his concern that the mass might be cancerous, Dr. Nguyen ultimately decided to remove what he suspected was the adrenal mass and the kidney. Dr. Nguyen did not obtain informed consent from the patient or the patient's family before removing the kidney. The pathology report conducted following the surgery revealed that Dr. Nguyen removed a benign kidney and abundant fat, which contained a segment of the ureter, but that he did not remove the adrenal mass, as intended.

Dr. Nguyen saw Patient B for a two-week follow up visit at which time he recommended a second surgery to remove the adrenal gland. Dr. Nguyen gave the patient the option to have another surgeon perform the procedure, but the patient elected for Dr. Nguyen to perform the surgery. On April 22, 2015, Patient B returned to Dr. Nguyen for a second surgery where Dr. Nguyen planned to perform an open right adrenalectomy and removal of the gallbladder.[2] For the second surgery, Dr. Nguyen asked another general surgeon to assist in the procedure. Dr. Nguyen removed the gallbladder without incident and removed a mass, which both surgeons thought was the adrenal mass. Dr. Nguyen then sent the mass to pathology for analysis to confirm that the mass removed was in fact the adrenal mass.

The pathologist reported a distinctly lobulated lesion measuring 6.5 x 4.5 centimeters, which appeared to be different from the surrounding tissue. The pathology report, however conclusively determined that there was no evidence of any adrenal tissue in the mass that was submitted for analysis. At the conclusion of both surgeries, the right adrenal gland had not been removed.

[2] The patient also had symptoms of gallstones, which were confirmed by an ultrasound. (T. 346.) The patient elected to have his gallbladder removed during the second surgery. (T. 346.)

On March 17, 2015, the Board received a mandated 10-Day Report from the hospital notifying the Board that Dr. Nguyen agreed to a voluntary suspension while a formal investigation was completed by the Medical Executive Committee. The Board initiated an investigation, and, as a result of the Board's investigation, charges were issued. The proceedings in this case stemmed from the Board's charges which were issued on January 20, 2016.

UNDISPUTED ISSUES

Before addressing the exceptions filed by the State, the Panel notes that neither party filed exceptions pertaining to the findings of the ALJ with respect to the surgery performed on Patient A. The ALJ found that the facts were undisputed and Dr. Nguyen admitted that he performed surgery on the wrong side and that his record-keeping was deficient. The Panel adopts the ALJ's undisputed findings of facts, conclusions of law, and discussion related to the wrong-side surgery that Dr. Nguyen performed on Patient A.

There were also no exceptions filed with respect to the ALJ's findings that Dr. Nguyen failed to meet the standard of care when he did not obtain informed consent for the removal of Patient B's kidney prior to the January 28, 2015 surgery and did not keep adequate medical records with respect to the pre-operative assessment of Patient B prior to the January 28, 2015 surgery. The Panel adopts the ALJ's undisputed findings of facts, conclusions of law, and discussion related to the standard of care and record keeping violations that the ALJ found for Patient B.

EXCEPTIONS

In its exceptions, the State requests that the Panel reject the ALJ's findings that Dr. Nguyen's failure to remove Patient B's right adrenal gland and the removal of Patient B's healthy right kidney did not constitute professional incompetence or a failure to meet appropriate

standards for the delivery of quality medical and surgical care. It is undisputed that the goal of Patient B's surgery was to remove a 5.5 centimeter mass attached to the adrenal gland. Dr. Roland, the State's expert, testified that Dr. Nguyen failed to meet the standard of care because he intended to remove the adrenal gland and failed to do so. Dr. Roland also opined that Dr. Nguyen was professionally incompetent because he did not demonstrate that he could effectively remove an adrenal gland. Dr. Lin testified on behalf of Dr. Nguyen and explained that while the removal of the adrenal gland was the intended procedure, it was only the working premise and that the actual goal of the surgery was to remove the mass that was identified on the preoperative studies. Accordingly, Dr. Lin opined that Dr. Nguyen did not violate the standard of care by failing to remove the adrenal gland mass. The ALJ agreed with Dr. Lin that the failure to remove the adrenal gland mass was not a violation of the standard of care nor indicative of professional incompetence. The Panel agrees.

The State also argues that Dr. Nguyen was professionally incompetent and violated the standard of care when he removed Patient B's healthy right kidney without a justifiable basis to do so. The State argues that Dr. Nguyen could have, but did not take frozen sections of the mass to confirm his suspicions of cancer, consulted with another surgeon, or stopped the surgery to refer the procedure to another surgeon in lieu of removing the patient's healthy kidney. Dr. Nguyen testified that he removed the kidney because he suspected that the mass could be cancerous and he was unable to dissect the kidney from the mass. In Dr. Roland's opinion, there was insufficient indication of cancer to justify the removal of the kidney. The ALJ found that the removal of the kidney under these circumstances was reasonable because it was necessary to remove the mass and the kidney was adherent to the mass. The ALJ concluded that even though there was no malignancy or adrenal tissue removed, it was still reasonable for Dr. Nguyen to

remove the kidney based on the information available to him at the time of the procedure. The Panel agrees with the ALJ that the removal of Patient B's kidney under the circumstances presented in this case did not violate the standard of care or rise to the level of professional incompetence.

Finally, the State argues that the ALJ should have found that Dr. Nguyen failed to keep adequate medical records when he erroneously represented in his operative note that he removed the adrenal gland when he did not. Dr. Nguyen admitted that his documentation for Patient B could have been better, and the medical record keeping violation with respect to the pre-operative assessment is undisputed. While there were certainly deficiencies in Dr. Nguyen's record keeping, the Panel does not find that the description of removing the adrenal gland constituted a failure to keep adequate medical records because this is the procedure that Dr. Nguyen thought he performed at the time of the surgery.

CONCLUSIONS OF LAW

The Panel concludes that Dr. Nguyen failed to meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical care for Patients A and B, in violation of Health Occ. § 14-404(a)(22), and failed to keep adequate medical records for Patients A and B, in violation of Health Occ. § 14-404(a)(40). The Panel does not find that Dr. Nguyen was professionally, physically, or mentally incompetent. Accordingly, the charge of professional, physical, or mental incompetence, Health Occ. § 14-404(a)(4), is dismissed.

SANCTION

The State takes exception to the ALJ's proposed sanction of a reprimand and a course in medical record keeping and requests that the Panel impose a reprimand and probation for a minimum of two years with conditions to include a course in medical recordkeeping, a Panel-

approved supervisor, and a peer or chart review. The State's recommended sanction, which included supervision, was based, in part, on the State's contention that Dr. Nguyen was professionally incompetent to practice surgery. The Panel, however, dismissed that charge.

Dr. Nguyen requests that the Panel adopt the ALJ's proposed sanction of a reprimand. The Panel agrees that a reprimand is appropriate in this case, but also believes that Dr. Nguyen would benefit from taking a Board-approved course in medical record keeping. Accordingly, the Panel will impose a period of probation for the length of time that it takes Dr. Nguyen to complete a Board-approved course in medical record keeping.

ORDER

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

ORDERED that Hien Nguyen, M.D. is **REPRIMANDED**; and it is further

ORDERED that Dr. Nguyen is placed on **PROBATION**[3] until he has complied with the following terms and conditions:

1. Dr. Nguyen shall successfully complete a Board disciplinary panel-approved course in medical record keeping. The course may not be used to fulfill the continuing medical education credits required for license renewal;
2. Dr. Nguyen shall be responsible for submitting written documentation to the Board of his successful completion of the course; and
3. Dr. Nguyen 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

[3] If Dr. Nguyen's license expires while he is on probation, the probationary period and any probationary conditions will be tolled.

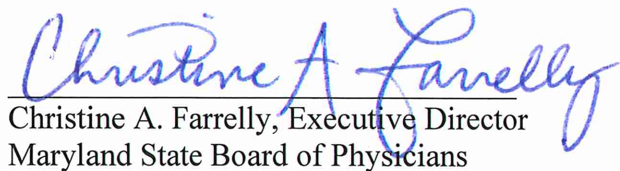
ORDERED that, after Dr. Nguyen has successfully completed the Board-approved medical record keeping course, presented documentation to the Board, and if there are no pending complaints related to the charges, Panel A or the Board will administratively terminate the probation. The administrative termination of probation will be issued through an order of Panel A or the Board; and it is further

ORDERED that if Panel A or the Board determines, after notice and an opportunity for a hearing before an Administrative Law Judge of the Office of Administrative Hearings if there is a genuine dispute as to a material fact or a show cause hearing before Panel A or the Board if there is no genuine dispute as to a material fact, that Dr. Nguyen has failed to comply with any term or condition of probation or this Order, Panel A or the Board may reprimand Dr. Nguyen, place Dr. Nguyen on probation with appropriate terms and conditions, or suspend or revoke Dr. Nguyen's license to practice medicine in Maryland. Panel A or the Board may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon Dr. Nguyen; and it is further

ORDERED that Dr. Nguyen is responsible for all costs incurred in fulfilling the terms and conditions of this final order; and it is further

ORDERED that this final order is a **PUBLIC DOCUMENT**.

05/18/2017
Date



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

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 14-408, Dr. Nguyen has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within thirty (30) days from the date of mailing of this Final Decision and Order. The cover letter accompanying this Final Decision and Order indicates the date the decision is mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Dr. Nguyen files a Petition for Judicial Review, the Board is a party and should be served with the court's process at the following address:

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

Notice of any Petition for Judicial Review should also be sent to the Board's counsel at the following address:

Stacey M. Darin, Assistant Attorney General
Office of the Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

Exhibit 1

MARYLAND BOARD OF	*	BEFORE LAURIE BENNETT,
PHYSICIANS	*	AN ADMINISTRATIVE LAW JUDGE
v.	*	OF THE MARYLAND OFFICE
HEIN NGUYEN, M.D.,	*	OF ADMINISTRATIVE HEARINGS
RESPONDENT	*	OAH No.: DHMH-MBP-71-16-15196
LICENSE No.: D57210	*	

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PROPOSED DECISION

STATEMENT OF THE CASE
ISSUES
SUMMARY OF THE EVIDENCE
PROPOSED FINDINGS OF FACT
DISCUSSION
PROPOSED CONCLUSIONS OF LAW
PROPOSED DISPOSITION

STATEMENT OF THE CASE

On or about January 20, 2016, the Maryland State Board of Physicians (Board) issued charges against Hein Nguyen, M.D. (Respondent) under the Maryland Medical Practice Act. Md. Code Ann., Health Occ. sections 14-101 *et seq.* (2014 & Supp. 2016). The Board forwarded the charges to the Office of the Attorney General for prosecution, and on May 17, 2016, the Board forwarded the matter to the Office of Administrative Hearings (OAH) for issuance of proposed findings of fact, proposed conclusions of law, and a proposed disposition. COMAR 10.32.02.03E(5), 10.32.02.04B(1).

I held a hearing on August 22 and 23, 2016. Md. Code Ann., Health Occ. section 14-405(a) (2014); COMAR 10.32.02.04. Stanley Reed, Esquire, represented the Respondent, who was present. Robert J. Gilbert, Assistant Attorney General and administrative prosecutor, represented the State of Maryland (State).

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules for Hearings Before the Board, and the Rules of Procedure of the OAH. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2014 and Supp. 2016); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

1. Was the Respondent professionally, physically, or mentally incompetent with regard to his treatment of Patient B?
2. Did the Respondent fail 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 with regard to his treatment of Patients A and B?
3. Did the Respondent fail to keep adequate medical records as determined by appropriate peer review with regard to his treatment of Patients A and B?
4. If so, what sanction is appropriate, if any?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following exhibits that the State offered:

1. Licensing Information
2. Mandated 10-Day Report, Hospital, received March 17, 2015
3. Letter to Respondent requesting response to Mandated 10-Day Report, May 7, 2015
4. Respondent's response (undated, received May 29, 2015)
5. Subpoena Ad Testificandum and Letter to Respondent requesting interview, June 5, 2015
6. Transcribed interview of Respondent, June 23, 2015

7. Subpoena Duces Tecum and Respondent's Quality Assurance File, Hospital

8. Subpoena Duces Tecum and Respondent's medical records for Patient A

9. Certification of Medical Records form for Patient A, July 30, 2015

10. Subpoena Duces Tecum and medical records for Patient A from Hospital

11. Subpoena Duces Tecum and Respondent's medical records for Patient B

12. Certification of Medical Records form for Patient B, July 30, 2015

13. Subpoena Duces Tecum and medical records for Patient B from Hospital

14. Peer review form

15. Curriculum vitae, Jason C. Roland, M.D.

16. Curriculum vitae, Rene L. Gelber, M.D.

17. Expert witness report, Dr. Roland

18. Expert witness report, Dr. Gelber

19. Addendum, Dr. Gelber

20. Letter to Respondent requesting supplemental response, October 29, 2015

21. Respondent's supplemental response, November 10, 2015

22. Report of Investigation, December 22, 2015

23. Charges Under the Maryland Medical Practice Act, January 20, 2016

I admitted the following exhibits that the Respondent offered:

1. Report of Paul Lin, M.D., FACS, of April 12, 2016

2. Curriculum vitae of Dr. Lin

3. Four Medical Journal Articles:

   A. The Accuracy of Multidetector Computed Tomography in Preoperative Staging of Renal Cell Carcinoma, by Liu, *et al.*

   B. Primary Retroperitoneal Neoplasms: CT and MR Imaging Findings with Anatomic and Pathologic Diagnostic Clues, by Nishino, *et al.*

C. Accuracy of Computed Tomography in Determining Resectability for Locally Advanced Primary or Recurrent Colorectal Cancers, by Farouk, *et al.*

D. Spiral Computed Tomography Assessment of Resectability of Pancreatic Ductal Adenocarcinoma: Analysis of Results, by Procacci, *et al.*

4. Dr. Lin's Reference sheet

5. May 7, 2015 Surgical Pathology Report of Patient B

6. Five certificates of continuing medical education completed by the Respondent:

   A. Risk Management Surgery, Second Edition

   B. Spotlight on Patient Safety: Avoiding Medical Errors, Second Edition

   C. Spotlight on Patient Safety: Disclosure of Medical Errors, Second Edition

   D. Risk Management Consult: Informed Consent, Second Edition

   E. Risk Management Consult: Documentation, Second Edition

7. Six reference letters for Dr. Nguyen:

   A. Dr. Prakash Vaidy, M.D.

   B. Dr. John Hebeka, M.D.

   C. Katie T** (a patient)

   D. Chris Gelmann, M.D.

   E. Allen Davies, M.D.

   F. Elizabeth Lowe, M.D.

8. Demonstrative Exhibits (8-A, C, D, E, F, G, H, I, J, K)

Testimony

The State presented the following witness: Jason C. Roland, M.D., accepted as an expert in general and minimally invasive surgery.

The Respondent testified and presented the following witnesses:

- Paul P. Lin, M.D., FACS, accepted an expert in general surgery
- Elizabeth Lowe, M.D., character witness
- Allen Davies, M.D., character witness

PROPOSED FINDINGS OF FACT

Having considered all of the evidence presented, I find the following facts by a preponderance of the evidence:

Background

1. The Respondent graduated from Temple Medical School in 1992 and completed a general surgery residency at Christiana Care Health Systems in Newark, Delaware, from 1996 to about 2001. He was chief resident the last year.
2. At all times relevant, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on or about March 13, 2001, under License Number D57210. The Respondent's license is currently active and is scheduled for renewal on September 30, 2017. Stipulation of the Parties.
3. The Respondent is board-certified in general surgery. Stipulation of the Parties. He has been board certified since 2003 and recertified in 2013 or 2014.
4. At all times relevant, the Respondent maintained a medical office at 300 East Pulaski Highway, Suite 104C, Elkton, Maryland 21921. Stipulation of the Parties. The Respondent works in private practice.
5. At all times relevant, the Respondent ha clinical privileges a Hospital Stipulation of the Parties. He was Chair of the Department of Surgery for two two- ear sessions.
6. The Respondent is also licensed to pract e medicine in Delaware. He let his hospital privileges in Delaware lapse because his work is primarily in Maryland.

7. The Respondent performs 600-800 surgeries per year (*e.g.* hernia repair, cholecystectomy, appendectomy, adrenalectomy, pancreatectomy, colon resection, small bowel resection and endocrine).
8. As a general surgeon, most of the Respondent's patients come by way of referral from specialists and primary care physicians.
9. The Respondent sometimes re-refers cases to tertiary care or university centers if he does not perform the required procedure. As a result of the incident with Patient B (described below), the Respondent is not currently performing adrenalectomies.
10. On a patient's first visit, the patient completes forms to describe his/her past medical history, past surgeries, medications, and referring doctor; some of this information is entered by the Respondent's medical assistant. The Respondent then sees the patient, asks the patient questions, and notes in the record the history of the patient's present illness. The Respondent enters information in the electronic medical records. The electronic record management system that the Respondent uses calls for him to check/click boxes on templates to record certain information and he can include narrative information not contemplated by check/click boxes.[1] The purpose of electronic recordkeeping is to maintain a paperless recordkeeping system.
11. A physician's obligation to keep adequate records, including affirmative examination findings, is not abated by the use of electronic records.
12. When the Respondent first saw Patient A, the Respondent was using new electronic medical recordkeeping software at his private practice.

[1] For example, the blocks for history of present illness and "general" and family history permit a narrative.

13. Various hospitals use different electronic recordkeeping systems. uses different software than does the Respondent. The Respondent has access to electronic records.

Patient A

14. A physician referred Patient A to the Respondent for surgical repair of a right-side inguinal hernia.

15. On December 23, 2014, Patient A had her first office visit with the Respondent. The Respondent did not previously know Patient A.

16. On the Patient's first visit with the Respondent, the Patient complained of lower abdominal pain, sharp constant pain for seven weeks, nausea without vomiting, constant diarrhea and a bulge in her abdomen. The Respondent documented that he performed an abdominal examination that included upper quadrant tenderness, but he did not document that he observed an inguinal hernia bulge, the location of the bulge according to the Patient, how long the Patient had the bulge, and whether the bulge was reducible.

17. The Respondent has performed thousands of hernia repairs.

18. The Respondent generally only examines the side of the patient's body where the patient complains of a hernia problem. Because Patient A had been referred for a right-side inguinal hernia, the Respondent examined only her right side. Even though the patient complained generally of abdominal pain, he did not examine her for a possible left-side inguinal hernia.

19. Patient A was scheduled for surgery on January 9, 2015, at

20. At 12:18 p.m. on the surgery day, the Respondent met with Patient A in the same-day surgery waiting room and executed a consent for surgery form for the right-side hernia surgery. Patient A signed the form. At that time, the Respondent marked with a pen the Patient's right thigh to designate that she was scheduled for right-side surgery.

21. The Patient was moved to the operating room and transferred to a surgical table.

22. The following individuals were in the operating room: Patient A; the Respondent; Piper Cratty, R.N., the circulating nurse; Christy Miller; the Respondent's surgical assistant; and Suzanne Lontor, the nurse anesthetist.

23. The operating room is customarily cold and someone covered the Patient with a blanket, inadvertently obscuring the pen mark on her right thigh.

24. At the time, had a "time-out" protocol for ensuring, among other things, that the correct patient was presented for surgery and the surgical team was proceeding with the correct surgery. The two-step protocol included having a designated person in the operating room call a time-out, meaning that everyone in the room would come to a standstill and a designated person would state out loud certain information, including the type and location of the surgery.

25. In Patient A's case, the circulating nurse, Piper Cratty, called the first time-out at 12:55 p.m. She read from the consent form, announcing loud and clear enough for the Respondent to hear and understand, that the Patient was scheduled for right-side inguinal hernia repair.

26. After the first time-out, the Respondent's attention was drawn to the Patient's left-side inguinal area because he observed a left-side hernia bulge. It is possible to have a hernia bulge while in the supine position. The Respondent prepared the Patient for left-side surgery by sterilizing and draping her left-side inguinal area.

27. Before the Respondent started the surgery, at 1:09 p.m., Nurse Cratty called the second time-out, again in a manner loud and clear enough for the Respondent to understand, that the Patient was scheduled for right-side inguinal hernia repair.

28. After the second time-out, the Respondent cut the Patient's left side inguinal area. He observed and repaired a left-side inguinal hernia.

29. After the surgery, the Patient was extubated and wheeled to recovery.

30. The Respondent started drafting his post-operative note and as he was typing the words "right side," he realized that he had performed left-side surgery. He examined the Patient to confirm he performed left-side surgery and read his history and physical to confirm that the patient was scheduled for right-side surgery.

31. The Respondent immediately advised the operating room charge nurse, the operating room director, vice president of "quality," and an anesthesiologist of the error, and they decided to talk to the Patient's husband about asking the Patient whether she wanted to proceed with the correct-side surgery. All or some of these people spoke to the Patient's husband in the waiting area and advised him of the error. They decided to advise the Patient of what happened and allow her to make a decision about whether to submit to a second surgery.

32. The Respondent waited for the effects of anesthesia from the first surgery to dissipate sufficiently so that the Patient could make an informed decision. The Patient had the ability to read, her comprehension was not impaired, she had an excellent ability to follow directions, and her speech pattern was appropriate and clear. As a result, the Respondent and John Hebeka, M.D., an anesthesiologist, reasonably determined that the Patient was sufficiently able to give conformed consent. The Respondent and hospital staff told the Patient in the recovery room that he performed the wrong-side surgery. The Patient elected to proceed with the correct-side surgery to be performed by the Respondent that day.

33. On January 9, 2015 at 3:19 p.m., the Patient signed a second consent form for the correct-side surgery. She underwent a successful right hernia repair.

34. The Respondent did not document in the Patient's surgical note that he observed a left side hernia bulge.

35. Union convened a Root Cause Analysis, the purpose of which was to determine what went wrong with Patient A's surgery and how to prevent similar mistakes in the future. Staff participated in three or four meetings, and Patient A and her husband participated in one of the later meetings. Patient A stated at the meeting that she did not understand at the time that she had wrong site surgery, even though she was specifically advised of the mistake in the recovery room after the first surgery and she executed a new consent form.

Patient B

36. Dr. Justin Sausville, Patient B's treating urologist, referred Patient B to the Respondent for right-side adrenalectomy. Patient B had undergone two CT Scans and two MRIs that revealed a suspected 5.5 cm (i.e., the size of a tennis ball) nonfunctioning retroperitoneal mass on his right adrenal gland.

37. The Respondent had known the Patient professionally for about two years prior to surgery.

38. The adrenal gland is flat and small, about 2 cm by 3 cm, and sits on the kidney. Non-functioning means the gland is not producing hormones.[2] The standard of care for a non-functioning adrenal gland larger than 4 cm is to remove it because there is an increased risk of malignancy.

39. The Respondent discussed with Dr. Sausville and an endocrinologist the likelihood that the retroperitoneal mass contained a malignancy.

40. The Respondent scheduled Patient B for an adrenalectomy.

41. The Respondent had sufficient training and knowledge of anatomical and vascular structures to perform laparoscopic surgery. He did not need the assistance of an urologist or other physician to perform an adrenalectomy.

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[2] The Respondent testified that because the gland was non-functioning, he did not have to worry about it secreting hormones while being manipulated in surgery. The State does not assert that the Respondent should have prepared otherwise.

42. Patient B also consulted with the Respondent for a thyroid nodule. The Patient had undergone an ultrasound-guided fine needle aspiration of the thyroid gland that was inconclusive for malignancy.

43. The Respondent first examined the Patient on December 22, 2014. He did not document in his office records the results of preoperative studies, including CT scans, MRIs and a workup about whether the adrenal gland was functioning.

44. Contrary to a report by the Patient's family member, the Patient did not previously have an aortic aneurysm repair. The Respondent knew this because such repair would have resulted in scars, which the Patient did not have, and the repair would have been seen, but was not seen, on imaging studies. Had the Patient had an aortic aneurysm repair, it would not have resulted in inflammation in the right adrenal gland area because the repair would have been done in a different part of the body.

45. Initially the Respondent was going to proctor Dr. Sausville in surgery, as he had done before, but at the last minute Dr. Sausville was not available. The Respondent elected to proceed with the surgery because he had done twenty adrenalectomies on his own and he was going to proctor Dr. Sausville in any event. The Respondent was capable of doing the surgery on his own.

46. Surgery was scheduled for January 28, 2015, at .

47. is a community hospital, not a tertiary care hospital. It is not necessary to perform an adrenalectomy in a tertiary care hospital.

48. The Respondent planned a right thyroid lobectomy with frozen section[3] and a laparoscopic right adrenalectomy in the same surgery.

[3] The Respondent explained that "for the thyroid gland, usually, you have a nodule on one side or the other. Even though the gland is in continuity, meaning there's only one gland, we call it sided." Tr. 326.

49. A frozen section means that a specimen is embedded in a gelatin-like substance after which it is frozen, stained and sectioned. A pathologist is able to look at the tissues under a microscope to determine whether the tissue is normal, inflammatory, or malignant. Usually it is possible to do a frozen section of the thyroid while the patient is on the operating table. If the frozen section shows cancer, the protocol is to remove the thyroid. If the section is inconclusive or shows no malignancy, the remainder of the thyroid is not removed. Sometimes the section is negative for malignancy, but the final report, issued after surgery is finished, shows a malignancy and the patient must return to surgery. A frozen section that shows no malignancy may represent a sampling error or an inaccurate reading by the pathologist.

50. The frozen section of the thyroid nodule was important because a negative result – that is, a section that does not show malignancy – allowed the Respondent to avoid removing the entire thyroid gland needlessly. Removing the entire thyroid gland renders a patient hypothyroid and thus dependent on hormone replacement medication for life, and doubles the risk of injury or a complication to the parathyroid, which are the glands that sit behind the thyroid and are responsible for calcium metabolism, and the recurrent laryngeal nerve which controls the vocal cords. It is therefore in a patient's best interest not to have both sides of the thyroid gland removed.

51. The Respondent has performed about 200 thyroid surgeries.

52. The Respondent met with the Patient on the day of surgery, January 28, 2015, to obtain a consent for surgery, including a right-side thyroid lobectomy with frozen section and possible total laparoscopic right adrenalectomy, possibly "open" (i.e., not performed laparoscopically). In the twenty prior adrenalectomies that the Respondent previously performed, it was not medically necessary to also perform a nephrectomy.

53. Because the Respondent had no reason to believe preoperatively that nephrectomy would be medically necessary, the Respondent did not discuss the possibility of that procedure with the Patient.

54. On the date of surgery, Patient B was morbidly obese. He was 67 inches tall, weighed 241 pounds, and had a body mass index of 37.74. He had diabetes and hypertension.

55. The Respondent first proceeded with the thyroid surgery. He performed a right-side lobectomy that he sent to pathology for a frozen section. The pathologist performed the frozen section immediately; the section was negative for malignancy. The Respondent therefore did not remove the remainder of the thyroid. He closed that portion of the surgery without incident.

56. The Respondent then repositioned Patient B on the operating table to prepare for the laparoscopic adrenalectomy. The Respondent filled the Patient's abdomen with carbon dioxide gas and made incisions through which a camera and other surgical instruments were placed.

57. The Respondent retracted the liver He did not have cause to "take down" the right triangular ligament. He mobilized tissue in the vicinity of the kidney and adrenal gland, including the colon and duodenum. He kocherized the duodenum to see better. He observed desmoplastic reaction which could be fibrous tissue around a malignancy or scar tissue. After he mobilized the organs, he encountered an approximately six-inch wall of abdominal fat which

contained the adrenal gland and in which the kidney sat.[4] The wall of fat made it especially difficult to find the mass within. Complicating matters was the desmoplastic reaction. The desmoplastic reaction can make tissues so sticky that it obliterates any normal tissue planes that should be seen.[5] In the absence of desmoplastic reaction, the adrenal gland is easily separated from the kidney because a clean plane exists between them.

58. The Respondent removed a lot of fat from the retroperitoneal space.

59. Cancer creates its own blood supply on which the cancer feeds. This process is called neovascularization. The Respondent observed blood vessels that are not named in any textbook, or at least not belonging to the adrenal vein or the adrenal artery.

60. The Respondent tried to dissect the adrenal mass from the kidney for about ninety minutes, but he was not able to do so because of inflammation. The Respondent decided that he needed to use his hand to feel the mass. He inserted a GelPort into one of the instrument's incisions. The GelPort is large enough for a surgeon to insert his/her hand into the abdominal cavity while maintaining the carbon dioxide gas inflation. The procedure allows the surgeon to receive tactile feedback while continuing with the surgery laparoscopically.

61. The Respondent felt with his hand what he believed was the adrenal mass that was reflected in the pre-surgical imaging studies. He continued to try to dissect it from the kidney.

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[4] The Respondent describe what he encountered:

> In this patient, this is where the difficulty of this case is, is that with his morbid obesity, he had a lot of retroperitoneal fat.
>
> So when you're obese, not only is your abdominal wall fat, but your omentum, which is the covering of the intestines, has a lot of fat, but your back, or retroperitoneal, has a lot of fat.
>
> So an analogy I can give is somebody who is thin has an abdominal wall like this. (Indicating.) Somebody who is obese has like a six-inch abdominal wall of fat. So that's how much fat the adrenal gland and the kidney is sitting in and this mass was sitting.

Tr. 332.

[5] A lay analogy is that each page in a book is a plane, and desmoplastic reaction makes the pages stick together and makes it difficult or impossible to separate the papers from one another.

Ultimately, the Respondent was unable to dissect the mass from the kidney and he removed them *en bloc*, meaning he removed both the suspected adrenal mass and the kidney.[6]

62. The Respondent did not do a frozen section because it was medically necessary to remove the mass even if it was benign.

63. Pathology studies showed that neither the mass nor the kidney was malignant and the mass did not actually contain adrenal tissue. Moreover, the mass the Respondent removed was not the one shown in the pre-surgical imaging studies.

64. The Respondent saw Patient B for a two-week follow-up at which time he recommended a second surgery to again try to remove the adrenal mass. The Respondent offered the Patient an opportunity to go to a tertiary hospital, but the Patient declined because he had faith in the Respondent and he did not want to travel far.

65. At the time of the second surgery, the Patient had symptoms of gallstones and he wanted the Respondent to remove the gallbladder as well as perform a right-side inguinal hernia repair.

66. For the second adrenal surgery, the Respondent decided to do open procedure because of the prior problematic laparoscopic procedure. The Respondent had Prakash Vaidy, M.D., help him because of Dr. Vaidy's experience with open adrenalectomies.

67. At the second surgery, the Respondent first performed the cholecystectomy without incident. Even though the Respondent removed a lot of fat in the first surgery, the Patient still had a lot of retroperitoneal fat and inflammation.

68. The Respondent performed a cholecystectomy and hernia repair. He observed peritoneal fat and an inflammatory process. Dr. Vaidy and the Respondent felt a hard mass that they

[6] The State asserts that the Respondent "ripped" the kidney out. The term "ripped" implies that the Respondent was violent or otherwise inappropriate. The evidence does not support such a finding. The pathologist noted only a "presumed recent laceration of the renal cortex medially to a depth of 0.5 cm." State Ex. 13, HN 11151.

reasonably assumed harbored the adrenal gland. They dissected off the mass and sent it for a frozen section to ensure the Respondent removed the adrenal gland.

69. The pathologist noted a distinctly lobulated lesion measuring 6.5 x 4.5 cm that was different than the surrounding fatty tissue. The pathologist did not observe adrenal tissue or any evidence of cancer.

70. The mass was not the one seen on imaging studies conducted before the first surgery.

71. Immediately following surgery, the Respondent dictated a brief surgical note. He did not dictate his full operative report until February 5, 2015.

72. Patient B did not have an adrenal carcinoma and he still has his right adrenal gland.

Miscellaneous

73. The Respondent has completed ongoing education on medical documentation. He has stopped performing adrenalectomies pending this hearing.

74. On March 17, 2015, the Board received a Mandated 10-Day Report (the "Report") from Union. The Report stated as follows:

> [The Respondent] was involved in a Sentinel Event, Wrong Site Surgery, on 01/19/15 [sic].[7] While this was under root cause analysis, [the Respondent] was the provider in a case where the patient was consented for a laparoscopic right side Adrenalectomy. [The Respondent] performed a right side nephrectomy. This case was sent for external review. [The Respondent] agreed to a voluntary suspension while a formal investigation was completed by the Medical Executive Committee (2/12/15-3/6/15).
>
> The Medical Executive Committee has concluded their investigation and has formulated an action plan. The MEC Action Plan has been presented and approved by the Board of Trustees on March 6, 2015. The approved plan includes CME requirements, involvement in patient safety and quality at Hospital, FPPE for Cause, as well as zero tolerance policy for non-compliance.

State Ex. 2, HN 10001; Stipulation of the Parties (footnote in original).

[7] According to the surgical note, the surgery took place on January 9, 2015.

75. After receiving the Report, the Board initiated an investigation of this matter. Stipulation of the Parties.

76. On March 20, 2015, the Board issued a subpoena to for the Respondent's quality assurance file. Stipulation of the Parties.

77. In a mailing received by the Board on April 9, 2015, provided the Respondent's quality assurance file. Stipulation of the Parties.

78. On April 13, 2015, the Board issued a subpoena to for the medical records for Patients A and B. Stipulation of the Parties.

79. In a mailing received by the Board on April 16, 2015, provided the medical records for Patients A and B. Stipulation of the Parties.

80. By letter dated May 7, 2015, the Board requested that the Respondent provide a written response to the Report. Stipulation of the Parties.

81. On May 7, 2015, the Board issued a subpoena to the Respondent for his medical records for Patients A and B. Stipulation of the Parties.

82. In a mailing received by the Board on May 26, 2015, the Respondent provided his medical records for Patients A and B. The Respondent stipulates to the authenticity and completeness of these records. Stipulation of the Parties.

83. In an undated letter, received by the Board on May 29, 2015, the Respondent provided a written response that addressed the matters referenced in the Report. Stipulation of the Parties.

84. By letter dated June 5, 2015, and through a subpoena dated June 5, 2015, the Board directed the Respondent to appear for an investigative interview at the Board's offices. Stipulation of the Parties.

85. On June 23, 2015, the Respondent appeared at the Board's offices and was interviewed by Board investigators. Stipulation of the Parties.

86. On July 30, 2015, the Respondent submitted Certification of Medical Records forms to the Board for Patients A and B. Stipulation of the Parties.

87. On August 18, 2015, the Board transmitted this matter to its peer review agent, Permedion, for a peer review of this matter. Two reviewers, Jason C. Roland, M.D., and Rene L. Gelber, M.D., performed the review. Stipulation of the Parties.

88. Jason C. Roland, M.D., issued a report of his findings, dated October 15, 2015. Stipulation of the Parties.

89. Rene L. Gelber, M.D., issued a report of his findings, dated October 21, 2015. Stipulation of the Parties.

90. By letter dated October 29, 2015, the Board provided the Respondent with the peer review reports and requested that he provide a supplemental response to the findings of the peer reviewers. Stipulation of the Parties.

91. By letter dated November 10, 2015, the Respondent provided a supplemental response to the Board. Stipulation of the Parties.

92. On November 19, 2015, Dr. Gelber submitted an addendum to his report to the Board. Stipulation of the Parties.

93. On January 20, 2016, Disciplinary Panel B of the Board issued disciplinary charges against the Respondent alleging that he violated the following provisions of the Maryland Medical Practice Act under Md. Code Ann., Health Occ. II section 14-404: Health Occ. II section 14-404(a)(4), Is professionally, physically or mentally incompetent; Health Occ. II section 14-404(a)(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 Health Occ. II section 14-404(a)(40), Fails to keep adequate medical records as determined by appropriate peer review. Stipulation of the Parties.

94. The Respondent has no prior disciplinary actions.

95. As a result of the matters with Patients A and B, the Respondent voluntarily undertook an evaluation by Maryland Health Physicians to prove to that he was not using drugs or having other health problems that would interfere with his ability to perform his job. He was drug tested, the results of which were negative. His nails and hair were tested to show no drug use for the prior six months. The Respondent drinks socially and alcohol does not interfere with his personal life. He was evaluated for depression or anxiety, the results of which were negative.

DISCUSSION

The Respondent is subject to disciplinary action for violating the Maryland Medical Practice Act, Md. Code Ann., Health Occ., sections 14-404(a)(22) and (a)(40).

Subject to the Respondent's right to this hearing, a disciplinary panel may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee is professionally, physically, or mentally incompetent (section 14-404(a)(4)); 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 (section 14-404(a)(22)); or fails to keep adequate medical records as determined by appropriate peer review (section 14-404(a)(40)). For the following reasons, I find that the Respondent is subject to disciplinary action under subsections (a)(22) and (a)(40) but not (a)(4).

At the outset, I will comment on the expertise of the Respondent's expert, Dr. Lin, and the State's expert, Dr. Roland, who was also a peer reviewer for the Board in this case. Both

physicians are accomplished surgeons with impressive credentials and they offered useful testimony.

Dr. Roland is licensed to practice medicine in in Maryland, Ohio and the District of Columbia. He is board-certified. He has no disciplinary actions in any jurisdiction.

Dr. Roland performed a residency in general surgery at the George Washington University, where, coincidentally, he was under the direction of Dr. Lin for about six years. (Dr. Lin testified that Dr. Roland is a good surgeon.) During the residency, Dr. Roland performed emergency and elective surgical procedures, including trauma, oncology, gastrointestinal, hernia and breast. He was a research fellow at Inova Regional Trauma Center. He was a Minimally Invasive Surgery Fellow and Clinical Assistant Professor at Ohio State University. As a fellow, he performed laparoscopic surgery and other procedures. He performed five adrenalectomies, all under the general supervision of another physician. Dr. Roland is currently employed by GS Medical Services, LLC, and is a surgeon and partner in private practice.

In his private surgical practice, he has privileges at the MedStar Good Samaritan Hospital, where he provides emergency surgery to trauma patients in the emergency room, including procedures ranging from appendicitis to ruptured bowels and hernias. About 70% of his practice is minimally invasive, from laparoscopic gallbladder removals to more complicated surgeries such as hernia repairs, colon resections, stomach resections, and paraesophageal hernias. About 95% of Dr. Roland's practice is clinical and surgical. Since 2008, he has performed approximately 400 surgeries per year.

Dr. Roland has extensive training in the repair of inguinal hernias, which he described as one of the three or four most common operations he performs. Dr. Roland does not perform nephrectomies which he said is usually performed by a urologist at his hospital.

Dr. Lin graduated from Harvard Medical School after which he did a general surgery residency, research and a fellowship at Johns Hopkins Hospital. The fellowship was in surgical oncology surgery, in particular liver, bile duct and pancreas surgery.

After an eight-year stint at Johns Hopkins Hospital, Dr. Lin joined the full-time faculty at George Washington University, where he has been for twenty years. He has been chief of general surgery since 2003; the vice chair of the department of surgery since 2003; and the program director for general surgical residency since 1997. Because he is the program director of residency, he teaches twenty-five to thirty residents per year. Although Dr. Lin teaches at George Washington University, he spends the majority of his time seeing patients and performing surgery. He has performed on average five to ten adrenalectomies per year for a total of about 150-200.

Dr. Lin has been retained as an expert 80-100 times in matters involving physicians. Over the years, he has served as an expert for one side or the other at about a 50-50 ratio, although lately it has been about 60% for physicians. He has testified as an expert about twenty to twenty-five times.

The State questioned Dr. Lin about the compensation he received from the Respondent for his testimony, the obvious purpose of which was to establish a financial interest in his testimony and bias in favor of the Respondent. Dr. Lin testified that he is paid $5,000.00 for the day at the hearing and $400.00 per hour for preparation for the hearing, such as writing a report. He estimated that he has spent a total of ten to fifteen hours preparation time. As to his report, the State asked if he wrote it, which he did, and whether anyone suggested any wording. Dr. Lin answered that he may have verified some factual points, but the narrative in the report is his own.

I do not find that Dr. Lin's expert testimony should be discounted in any way based on his compensation and the evidence does not show that anyone influenced his opinion. Dr. Lin's

credentials are impressive, payment for preparation and testimony is customary, and the record does not show that he would compromise his integrity to reach a particular outcome. Also, Dr. Lin's testimony was not always favorable to the Respondent, as I will explain later. Thus, he has proven to have an open mind and the ability to be critical of the Respondent.

While I am impressed with the training, education and experience of both doctors, and their expert testimony was useful, I give more weight to Dr. Lin's opinions than Dr. Roland's when evaluating whether the Respondent violated the standard of care for performing adrenalectomy surgeries on Patient B. Dr. Roland has only performed five adrenalectomies, all under supervision many years ago. Dr. Lin performs about five to ten per year. I therefore find that Dr. Lin has more experience in the specific surgery at issue.

Both physicians are equally qualified to offer expert opinions on Patient A's inguinal surgery repair. Their expert opinions in this case are substantially the same and yield to the Respondent's concession that he violated the standard of care, as I will discuss further later in this Discussion.

I turn now to the substantive issues for Patients A and B.

Patient A

The State asserts that the Respondent performed a wrong-side, or wrong-site, surgery on Patient A. The facts are not in dispute. In short, about thirty minutes before surgery, the Respondent obtained the Patient's consent for a right-side hernia repair but nevertheless performed a left-side hernia repair; while the Patient was in the operating room but before the Respondent made the first incision, operating room staff called two standard time-outs during which time staff announced that the surgery was on the right side; the Respondent admitted his "horrible" mistake; and that same day, the Respondent took the Patient back to surgery and performed the right-side hernia repair. The State questions whether the Patient even had a

left-side hernia and whether the Respondent observed a left-side hernia bulge. The State suggests that the Respondent somehow pretended to perform the left-side surgery to cover having mistakenly cut the Patient's left side. The State further questions whether the Respondent told the Patient that he performed the wrong-side surgery and obtained appropriate consent to do the second surgery.

The Respondent does not contest that he performed a wrong-side surgery when he repaired Patient A's left-side hernia after she consented to right-side repair. The Respondent testified that even though he had every reason to know the Patient was scheduled for right-side hernia repair, he was drawn to the Patient's left side by a left-side inguinal hernia bulge. Although he did not document the left-side bulge in his operative note or elsewhere, I accept the Respondent's testimony that it existed.

First, Dr. Lin testified that it is possible for a patient to exhibit an inguinal hernia bulge while in the supine position and under anesthesia, as was the Patient. Dr. Lin testified:

> It may be true that many patients will not have a bulge while they're under anesthesia, but the variable factors involved would be how deep of an anesthesia level that patient is at the time that [the Respondent] was looking at the area. That's one.
>
> Two, it all has to do with what contents were in the hernia sac and whether it be bowel, as shown in this illustratio 1 [at Respondent's Exhibit 80-J].
>
> Some of that tissue that's coming through that hernia defect may not be so free to go back in even if the patient is under anesthesia and generally relaxed.

Tr. 165. Dr. Lin conceded that the Respondent did not note in his operative report of the left-side inguinal hernia any infiltration of the bowel into the inguinal canal. He nevertheless did not discount the possibility of other tissues pushing up to create the left bulge the Respondent saw. While Dr. Lin qualified his answer, his testimony that it was possible for the Respondent to see the bulge is not refuted.

Second, the Respondent in fact repaired the left-side inguinal hernia; thus, the presence of a left bulge is plausible. If the Respondent pretended to perform left-side hernia surgery, I would have to conclude that he falsified the operative note that he drafted about the procedure. The evidence simply does not establish that the Respondent would have gone to such lengths to cover for having inadvertently made a left-side incision.

Third, the State suggests that no one in the operating room had the skill to notice the Respondent was not actually performing a left-side repair. The evidence does not show that the professionals present lacked such knowledge. I find it likely that even non-physician surgical staff would recognize whether a surgeon was actually performing surgery or just faking it. The State did not present any evidence of the contrary.

Also, even Dr. Roland saw no reason to doubt that the Respondent perceived a left-side bulge. Dr. Roland testified that he saw no indication in the hospital medical records or the hospital's investigation records to suggest that anyone in the operating room claimed otherwise.

Thus, while the record undoubtedly shows that the Respondent initially performed the wrong surgery, he in fact repaired a left-side inguinal hernia. The Respondent documented the specifics of the hernia repair surgery in a post-operative note. He documented the preparation and incision on the left side, after which he wrote:

> The patient had a defect noted from the abdominal wall. There was a large defect noted near the internal ring consistent with a direct inguinal hernia. This was done after scar tissue was all taken down. I bluntly dissected out the preperitoneal space. I chose a medium PHS mesh, placed it in the preperitoneal space and flattened it out. The onlay mesh was placed on the floor of the inguinal canal and stitched to the pubic tubercle, inguinal ligament and conjoint tendon superiorly. The lateral portion was placed underneath the scar tissue. I irrigated the area and closed the subcutaneous tissue with 3-0 Vicryl interrupted stitches.

State Ex. 10, HN 10378.

The State questioned Dr. Lin about whether the Respondent simply forgot that he was supposed to perform a right-side surgery. Dr. Lin found no evidence of that, and neither do I.

While it is true that the Respondent took the Patient's consent for the right-side surgery roughly forty minutes before surgery and he clearly heard two time-outs announcing right-side surgery, the record does not show he performed a left-side because he forgot what he was supposed to do. The record does not show that the Respondent was forgetful.

The Respondent committed an "error in judgment," which Dr. Roland defined as "a medical error where you are judging something to be one thing and it turns out your judgment is incorrect." Tr. 118. Dr. Roland agreed that the Respondent acknowledged his error in judgment as to the wrong-side surgery – in other words, the Respondent made an error, but he did not knowingly operate on the wrong side. The Respondent was appropriately remorseful of his error in judgment. Although he offered an explanation, he did not offer excuses. Dr. Roland testified that a physician can have an error in judgr ent without breaching the standard of care. As to the wrong-side surgery, he held firm to his o nion that operating on the wrong side is both an error in judgment *and* a breach of the standard f care. Dr. Roland further testified that this breach of the standard of care does not rise to the l vel of unprofessional conduct nor reflect that the Respondent is incompetent as a surgeo .

The Respondent noticed that h performed the wrong-side surgery while the Patient was in recovery. He notified hospital auth rities and the Patient's husband. Together they decided to wait until the Patient was alert enoug to understand the error to decide whether to proceed with the correct-side surgery that same da The Patient consented to the second surgery and it proceeded that same day.

During the hospital's Root C use Analysis, Patient A complained that she did not know at the time that the Respondent had performed wrong-side surgery. Indeed, T Medical Executive Committee notes/report provides that, "In the wrong site case, [the Respondent] failed to adequately disclose information to patient and spouse. This resulted in the patient not fully

understanding that a wrong sided surgery had occurred and a level of confusion ensured as to what actually occurred." State Ex. 7, HN 10030. The evidence shows, however, that hospital staff and the Respondent did not consult with Patient A until they believed, based on their professional judgment, that she was capable of understanding what had happened. The Patient then signed a new consent for the second surgery performed the same day as the first. The only relevant evidence to support the committee's finding is the Patient's statement that she did not understand what happened to her. Her statement is not credible, though, because she was assessed and shown to have the ability to understand before she was asked about returning for a second surgery.

The State also complains that the Respondent violated the standard of care by not performing a pre-operative examination of the Patient's left-side inguinal area for a possible left-side hernia, alleging that the standard of care required that he also examine the left inguinal area. The Respondent testified that he only examined the right inguinal area because the Patient was referred for a right inguinal hernia and he had no more cause to examine the left inguinal area than he did other areas of the body. Dr. Roland testified that:

> [F]or a matter of completeness, the standard would be to examine both the right and the left side to determine whether there's a hernia on the other side, as well, especially if the patient's symptoms are vague.
>
> We don't really have a good sense based on the history. She just had lower abdominal pain. So unless they were complaining specifically of pain on one side or the other, you probably would want to examine both.
>
> In fact, even if they were complaining of pain on just one side, I would say that the standard would be to examine both inguinal areas.

Tr. 48-49. Dr. Roland further testified that a left-side inguinal examination would have taken a few seconds to complete. The Respondent testified that it would have taken two seconds.

Dr. Lin agreed that the standard of care requires examination of the left inguinal area when assessing a patient for an inguinal hernia and "most often" he would examine the patient

bilaterally and he was "to do a comparative thing and see how one side compares to the other and just in case there's a hernia on the other side." Tr. 232. Dr. Lin testified further that he instructs his residents to document the results of the bilateral examination.

The Board charged the Respondent with violating the standard of care by not obtaining consent for the left-side hernia repair. The Respondent did not obtain consent because he planned to do a right-side hernia surgery; he had no reason to obtain consent for the left-side surgery. The Respondent did not knowingly or negligently fail to obtain consent. That said, the Respondent does not dispute that he initially operated on the wrong hernia.

In addition to performing the wrong-side surgery, the Respondent's medical records pre- and post-surgery are deficient. For example, Dr. Roland criticized the insufficiency of the Respondent's pre-operative note. Dr. Roland opined that even though a physician previously diagnosed Patient A with a right-side hernia, the Respondent should have documented that he actually found a hernia, the location of a bulge (i.e., at the umbilicus, the groin, or the middle of the abdomen), the duration of the bulge, and whether the bulge enlarges with certain maneuvers, specifically where the bulge is located and whether the bulge is reducible. Dr. Lin testified that the note is typical of what most physicians currently prepare. The State questioned Dr. Lin about the absence of any mention in the Respondent's pre-operative examination notes of a left-side bulge. Dr. Lin agreed that adequate recordkeeping would require such a notation, if a left-side bulge existed at the time. The evidence does not show that the Respondent observed the left-side bulge when he examined the Patient in anticipation of surgery. The referring physician did not note a left-side bulge or left-side hernia. Thus, while the Respondent's records are deficient in other ways, they are not deficient for his failing to document a left-side hernia bulge during his examination of the Patient in his office.

Although the Respondent disagrees that his records are deficient in every way that Dr. Roland described, he concedes that his records could have been more complete. Dr. Lin opined that the recordkeeping was deficient. For example, the Respondent did document that the Patient complained of abdominal pain, but he was not more specific regarding the location of the pain and the duration of the pain.

Dr. Lin testified that the increasing use of electronic medical records which contain templates with pre-populated information that a physician may modify, muddies the conversation about recordkeeping. He explained an increasing number of doctors assume that everyone working with a particular patient will have access to all of the patient's electronic records. The Respondent blames his deficient records in part on the use of electronic medical recordkeeping, which is new to him (or at least the software he uses is new to him). He testified that he sometimes wrote what he believes referring physicians were looking for, that the electronic templates hamstrung his ability to include certain information, and that the templates are geared toward insurance needs. Whatever the reason, the records were deficient. Again, the Respondent does not contest this fact and his expert agrees that his records were in some ways deficient.

In sum, the Respondent failed 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 (§ 14-404(a)(22)), and failed to keep adequate medical records as determined by appropriate peer review (§ 14-404(a)(40)).

Patient B

As to Patient B, the State asserts that the Respondent again did not keep adequate medical records, he violated the standard of care, and he was professionally incompetent when he removed a healthy kidney during surgery to remove a possibly cancerous adrenal gland and

performed two adrenalectomy surgeries without actually removing the adrenal gland.[8] Moreover, the State asserts that the Respondent was professionally incompetent because the Respondent twice claimed to remove the adrenal gland and twice did not remove it; and he needlessly performed a nephrectomy.

With respect to the Respondent's recordkeeping of Patient B, Dr. Roland testified that the pre-operative note is deficient. For example, in Patient B's second surgery, the Respondent performed a cholecystectomy. Dr. Roland testified, and the Respondent does not dispute, that the Respondent's preoperative records reflect only that the Patient requested gallbladder removal and hernia repair when he returned for the second adrenal mass surgery, but the Respondent did not document the reason for these procedures. He said:

> So whether the patient had gallstones, whether or not he was complaining of symptoms that sounded like biliary colic, which would be symptomatic, also, barring any other complication related to gallstones, I didn't see any documentation of that. He simply stated that [the patient] needed a cholecystectomy.
>
> He mentions the hernia and he does document that there is a right inguinal hernia present. He does not document, again, any discussion of any of this with the patient, not to infer that no discussion occurred, but certainly there isn't any documentation of it.
>
> But I think the standard of care would indicate for medical documentation that you would document all of that, at least rudimentarily.

Tr. 73-74.

Dr. Lin testified again about the role of electronic medical records:

> Whether I like it or not, or anybody else weighing in on this, (1) there is quite a variability in how physicians document things, especially nowadays with the electronic medical records. There may have been a little more consistency prior to this era of electronic medical records.

[8] The Respondent also performed a thyroidectomy on Patient B during the first surgery and a cholecystectomy and hernia repair during the second surgery. The State does not allege any standard of care violation as to performing these procedures.

But in this day and age, there's a lot of variability. There are going to be still some individuals who are a bit more old school who put it all together in one note largely for the convenience of other physicians.

But I see within my department and various other institutions, there are many more physicians who have the general understanding that all of those electronic records are available.

But it gets even more complicated than that in that so often there will be a separate electronic medical record system for the hospital and then a separate one for the physician's office himself; and yet, they all are accessible to the docs who are most involved in that case matter. And so more and more physicians are not condensing it all into one report.

I don't think there's anything contestable about whether those [adrenal mass imaging] studies were done or not and I don't think there was anything questionable about whether [the Respondent] did the due diligence to look at those studies and whether there was any disagreement between or amongst him and the other three or four physicians involved.

Tr. 191-192.

The issue is not, as Dr. Lin's testimony implies, whether the Respondent actually reviewed and considered the preoperative imaging studies; rather, the question is only whether the Respondent's medical records were adequate. Even taking into consideration that electronic medical records present a confounding factor, I find that the records were in some ways deficient, as Dr. Roland described.

The Respondent agreed that he could have done a better job documenting Patient B's circumstances preoperatively. The Respondent testified about what he wrote under "history of present illness" in his office note for the Patient: "The patient is seen in consultation for a right adrenal gland mass and right thyroid nodule. The patient has a 5.5 cm right adrenal mass. The Patient has had a non-functioning mass. The patient has also had an [ultrasound guided] [fine needle aspiration] of his thyroid gland that was inconclusive." State Ex. 11, HN 10389.

Responding to questions about the completeness of the note, the Respondent testified:

> Again, I mean, I've had a long-standing relationship with the patient. He's been in the hospital. He's had this work-up prior to me even seeing him. But like I saw all the other imaging studies and endocrine work-ups.
>
> For someone who does adrenal surgery, when they say a non-functioning, you know that it's already been studies, that all of the hormones that were secreted were all tested. So non-functioning means it's not secreting any hormones.
>
> For there to be size criteria, you know that you've had to have prior imaging because you can't just pick a number out of your head.
>
> So I knew that he had all of these studies prior to being in the hospital, and in subsequent evaluations that he already had this. So that's why I documented that. Could I have documented better? Absolutely.

Tr. 318.

The Respondent testified that he did not put the specific test numbers in his note "because, as you can see, it takes a whole paragraph to do that. I stated it succinctly, which is two sentences. And like I said, anybody who does a lot of adrenal surgery would know what those words mean, that the work-up had been done previously." Tr. 321-322. It is true that a surgeon could draw conclusions from the scant information that the Respondent included in his note. Nevertheless, it bears repeating that the Respondent agrees the note could have been more comprehensive.

The Respondent testified that he in fact received the CT scan and MRI reports and read them. Moreover, he testified that he consulted with the endocrinologist, or more accurately, the endocrinologist consulted with him. The record does not show otherwise. While I find that the Respondent did a thorough job preparing for surgery, the evidence shows that his records are deficient.

The next and obviously more serious issue is whether the Respondent breached the standard of care and was professionally incompetent when he performed a nephrectomy of

Patient B's right kidney and twice intended to but did not remove the Patient's right adrenal gland.

Dr. Roland started the discussion by addressing whether it was necessary to remove the adrenal mass at all. While Dr. Roland would have preferred to review the imaging studies of the mass before rendering an opinion about medical necessity, he did not take serious issue with the Respondent's decision to perform an adrenalectomy and thus did not find the decision to violate the standard of care:

> Preoperatively, certainly, there is documentation issues. Again, whether or not [the Respondent] actually reviewed personally the imaging studies, the two CT scans and the two MRIs, he may not have but it's certainly not documented.
>
> There's no documentation that any of the imaging – I'm sorry, the laboratory work-up was reviewed.
>
> When it came to the actual operation itself and the planning of the operation, I certainly think that the decision to operate on the patient to remove the adrenal gland of that size, which was non-functioning, does meet the standard of care, however, in this patient who is morbidly obese, diabetic, hypertensive, a lot of other comorbidities, one has to know this is going to be a challenging case from the outset.
>
> Again, without having the luxury of being able to review the imaging studies themselves or at least see a dictation of what a radiologist's opinion was, it's hard for me to draw a complete conclusion as to whether or not this – what he found in the – what he perceived to find in the operating room made any sense in the context of that preoperative work-up.
>
> That being said, I can only assume that it showed a 5.5 centimeter lesion in the place where the adrenal gland should be.

Tr. 75-76.

In fact, the record conclusively establishes that preoperative imaging studies showed that the Patient had a 5.5 cm adrenal mass; the State does not assert otherwise. Moreover, the record establishes that the standard of care for a non-functioning adrenal gland in excess of 4 cm is to remove it because there is an increased risk of malignancy; the State does not assert otherwise.

There was testimony about whether the Respondent breached the standard of care by not removing Patient B's right triangular ligament of the liver during the first surgery. Dr. Roland testified that is not necessarily a breach of care and he did not find a breach in Patient B's case.

Dr. Roland was asked whether the Respondent violated the standard of care by not taking additional studies of the adrenal mass between the first and second surgeries. Dr. Roland did not find a violation of the standard of care:

> And it's difficult to say that it's a standard of care, but certainly, given the intraoperative findings, it would have been a good idea to, perhaps, re-image the patient and see if there was a persistence of an adrenal gland or a mass in that area which was still there.
>
> Now, that study might have been limited by the postoperative changes, the scarring and the- probably whatever would have been left behind from the surgery, but it certainly could have been done.
>
> I would not say that I would say that's standard of care because, again, this is a very unusual circumstance. So it's hard to say exactly what the standard of care would be with regard to imaging, specifically.

Tr. 74.

The State suggests that the Respondent violated the standard of care by kocherizing the Patient's duodenum. Dr. Roland opined that it was unnecessary for the Respondent to perform the procedure. Dr. Roland described the duodenum "as the first part of the intestine as it comes out from the stomach. It creates a C-loop[.]" Tr. 134. Further, "kocherizing it implies taking down the attachments to it and being able to reflect it towards the middle of the patient to provide visualization." Tr. 135. Dr. Roland opined that kocherization provides more visibility, but he added that more visibility is not usually necessary.

Dr. Roland testified that a kocherization is not in and of itself a breach of the standard of care. He added that because Patient B was morbidly obese and his tissue planes were "likely difficult," he is concerned that the Respondent was operating more medially than he thought he

was. He conceded, though, that the Respondent may have kocherized the Patient because he needed to achieve a better visualization of the surgical field.

The Respondent testified that he had to "mobilize or koche[rize] the duodenum to reflect the small bowel out of the way so that [he could] focus on the retroperitoneum." Tr. 331. Dr. Lin agreed:

> If you remember what Dr. Roland said – he said that in his report, as well as earlier today – he said that duodenum, which he does describe accurately, would be a C-loop.
>
> He describes it as being, basically, to the patient's left of this vena cava, in so many words. He said "medial." The word he used is "medial." Medial means going toward the center of the abdomen, but because we're talking about the right retroperitoneal area, medial would mean going to the left there.
>
> ...
>
> ...the duodenum is in front of this whole area, but comes to the right of the vena cava and overlaps the adrenal gland. It comes around like this (indicating [on a picture]).
>
> That C-loop that Dr. Roland was talking about, it comes around like this. But it is in front of that adrenal gland. And so more than not or most often, for a surgeon to get to that area, whether it's laparoscopic or open, the surgeon would need to mobilize or do that koche maneuver, mobilize that whole duodenum there.
>
> And that's largely because not just to see the adrenal gland, but the more dicey or difficult part of the taking out that gland would be that there are these little blood vessels between the adrenal gland and the vena cava itself.
>
> And the adrenal gland is already abutting, stuck up against the vena cava, just as I was describing the liver is stuck up against the diaphragm. There's hardly any space there for the surgeon to work.
>
> And both of those things on either side of that tiny little cramped space can bleed. So, similarly, the adrenal gland is stuck up against the vena cava there.
>
> So, of course, for the surgeon to have the best access there, the surgeon would typically kocherize the duodenum, get it out of the way there, sweep it over to the left side medically.
>
> ...

> ...It is a C-loop of intestine, but it's so plastered against the backside of the retroperitoneum. So it would need to be peel off over to the patient's left side in order to do the reveal for the adrenal gland and the vena cava. The duodenum is very much overlapping the vena cava.

Tr. 211-213.

Thus, Dr. Lin opined that kocherizing the duodenum was not a breach of the standard of care. To the contrary, he found the procedure "quite sensible and, in fact, quite needed in most cases." Tr. 214.

It seems that Dr. Lin did not accurately summarize Dr. Roland's use of the word medial. Dr. Lin suggests that Dr. Roland thought the Respondent was moving the duodenum medially. In fact, Dr. Roland simply stated that he thought the Respondent might have been operating more medially than he realized. Nevertheless, based on Dr. Roland's testimony that the Respondent may have needed better visualization of the surgical field and Dr. Lin's testimony that kocherization of the duodenum is quite usual, I do not find that the Respondent violated the standard of care by performing the procedure.

The State asserts that the Respondent needlessly removed a healthy kidney. The Respondent testified that he removed the kidney because he could not dissect it from the mass and the mass had indicia of malignancy. He explained the conditions he observed with which he struggled before deciding to take the kidney *en bloc*:

> Q. In your operative report, you indicate in the section at the very bottom of page 10393, extending into 10394, you say the dissection – you said, first, "There was a lot of abundant fat given his obesity. The dissection was preceded superiorly of Gerota fascia. I had to remove a lot of fat in the retroperitoneal space. There was much more abundant fat than noted." What do you mean by all of that? What are you talking about?
>
> A. That's the fat that I was talking about in the back. When we have somebody who is morbidly obese, they have extra fat and the fat that they have is just huge.
>
> Q. You go on to say, "There also appeared to be a desmoplastic reaction concerning for malignancy"; correct?

A. Yes. That's the inflammation I'm talking about.

Q. And then you go on to say that, "I was able to see the adrenal gland on top of the kidney and was dissected out." Can you explain…what you are saying there?

A. Yes. I mean, anatomically I know where the adrenal gland is. Anatomically, I know where the kidney is.

When you have a mass that's growing there and when you have a concern for cancer, they don't play by the same rules. Everything gets obliterated, so there's no nice dissection planes.

Like these pages are easily stuck together. The only way I can describe is if you put glue on here and you stuck it together and then you're trying to peel it apart. That's what cancer is like.

So that's the desmoplastic reaction that I'm referring to.

Q. So when you say, "I was able to see the adrenal gland on top of the kidney and was dissected out," what does that mean?

A. I'm referring to the mass that I felt that I thought was the adrenal gland.

Q. You go on to say that, "There appear to be a lot of neovascularization consisted with possible malignant process," and you already explained that.

Then you go on to say, "The adrenal gland appeared to be densely adherent to the kidney. At this time I tried to dissection out inferiorly, laterally, superiorly.["]

"I dissected out the small adrenal arteries and veins with the ligature device…. After dissection superiorly, I then proceed laterally to dissect out the adrenal gland.["]

"Again, there was a lot of abundant fat which had to be transected along with the specimen."

So what's going on here? What are you doing now in this next step of the procedure?

A. My goal was to take out that mass and, because of the concern for cancer, I had to take out any organs that were attached to that mass, which happened to be the kidney. So that was my thought process at the time.

Q. Were you trying to save the kidney beforehand or how were you approaching this organ that you –

A. Absolutely. Like I said, my other 19 adrenalectomies, you always – I was always able to dissect it off of the kidney. But in this case, I couldn't.

Q. Are you familiar with the concept or principle, "en bloc…, resection?

A. Yes. You know, when you have cancer, whether it be of the colon, the pancreas, the small intestine, when that cancer invades the surrounding organs, it makes everything stick to itself. So you want to resect out the cancer with everything that's stuck to itself, because if you try to shave off the cancer from the other organ, you will leave behind cancer cells. And that's not a full oncologic or full cancer surgery. You're not helping the patient. So when you have a suspicion of cancer or feel that it is cancer, you want to resect out the organs, even if it's a normal organ that's attached to it and remove it en bloc, meaning in total with the cancer specimen. And I've done that for colon cancers. I've done that for small bowel cancers. I've done that, you know, for other cancers.

Tr. 334-337.

Dr. Lin further continued, explaining why imaging is not completely reliable and, importantly, explaining why it was necessary for the Respondent to remove the mass, and the kidney in the process, no matter what the frozen section would reveal:

> These CAT scans are known to not be so accurate, whether we're talking about the sensitivity or specificity or positive predictive value or negative predictive value.
>
> …
>
> But when a CAT scan is so suggesting to the radiologist, as well as any other clinicians involved, say a urologist and endocrinologist, the surgeon, suggesting that that mass is coming from one organ and not necessarily involving another organ, if you look at all of these studies, the accuracy really ranges. It would be as inaccurate as only about 50 percent accurate to maybe as accurate as 80 percent accurate. .
>
> And I'm purposely using the broader term "accurate" to include any of those statistical terms, sensitivity, specificity; meaning, you know, these CAT scans are being used reasonably to say whether the tumor looks resectable or not, resectable or inoperable. And there are a couple of easy ways to understand the fundamental meaning of resectable or operable.
>
> One way is that if the surgeon is going in to take out that thing, whatever that thing is, and in case that thing really is a cancer, of course, between the surgeon and the patient, the goal is to take it out and to take it out as completely as possible….

So sometimes it will be that the CAT scan is, perhaps, suggesting that that thing is coming from the adrenal gland and that it's not involving the kidney, which is right next to the adrenal gland....

But if you look in all of these studies, there is going to be inherently some degree of inaccuracy; meaning, when the surgeon finally is in there, he's going to, perhaps, find that the whole process is extending into either the outer lining of the kidney or into the kidney itself.

And then at that point, the surgeon only has a couple of choices. He either takes it all out so that he gives the patient the least chance of leaving some malignant cancer behind on some other organ or the surgeon leaves it all behind.

The problem is that it is not at all easy for the surgeon to figure out preoperatively if he's dealing with a cancer that's buried somewhere in that mass.

And then intraoperatively, as much as you've heard about the considerations of getting frozen sections, the truth of the matter is for anybody who does these operations enough, frequently enough, frozen sections for adrenal masses or retroperitoneal tumors are not very accurate. They are not very accurate.

And then if you sort of think it out, you, as in the surgeon, or anybody else who is trying to weigh in on this, if the intraoperative frozen section with the pathologist standing right there looking at the microscope, if that frozen section comes back suggesting tumor, it doesn't change the plans of the operation, which is to take that thing out, whatever it's coming from.

If the frozen section comes back negative or inconclusive, to the experienced surgeon doing these operations, that is not enough to think that that's the truth of the matter and then to stop the operation and then back out. It's actually not enough to do so as long as there is a mutual understanding between the surgeon and the patient.

....

There's also some ranges of false positives or false negatives or inaccurate suggestions. And then in the operating room, the frozen sections, the pathologists are trying to do their best to say the truth of the matter, and so often it is either indeterminate or flatly wrong.

And I'll see those all the time to the point that I so often don't bother with the frozen sections. I just go ahead and take out the tumor, which is why we do have those expressions of taking things out with impunity, even though it might mean sacrificing a kidney.

Tr. 182-185.

In short, whether malignant or benign, it was necessary to remove the tumor and because the tumor was densely adherent to the kidney, it was necessary to sacrifice the kidney. The Respondent did not perform a nephrectomy hastily. He explained that when he could not dissect the mass from the kidney using only laparoscopic instruments, he inserted a GelPort so that he could use his hand to feel the abdominal cavity and the mass in particular. He was still unable to complete the dissection.

Dr. Roland testified that when the Respondent could not remove the adherent mass, he should have stopped the surgery and consulted another physician or referred the Patient to a tertiary care hospital. On cross-examination, Dr. Roland was pressed on the decision to remove the kidney *en bloc* with the adrenal mass:

> Q. If [the Respondent] suspected a carcinoma that involved a kidney, it being adherent to a tumor, is it correct that it should be resected en bloc, that is, with the kidney, as well?
>
> A. I think it was mentioned with the other review that – I think he said it would be inconceivable that it couldn't be identified on the preoperative imaging studies.
>
> I think it's, as I said, I think highly improbable that four prior imaging studies would not have demonstrated that [the mass was *adherent*].
>
> ....
>
> Q. At the bottom [of Tab 17, page 5, of Dr. Roland's report], you say "Also, if there is suspicion of carcinoma, this can often be supported with intraoperative frozen pathological evaluation," which you testified about. Then you go on to say, "And it should be resected en bloc with any attached structures." Do you see that?
>
> A. Yes.
>
> Q. So would you agree that if [the Respondent] suspected a carcinoma that involved the kidney, it was appropriate for him to resect the structure that he thought was affected by the cancer en bloc?
>
> A. I think the burden of proof is a little bit higher than just looking at it and judging it to think it looks like cancer.
>
> ....

A. But you would agree that if there was a strong suspicion that you felt comfortable with and that removing a healthy kidney in that situation is something that –
A. Well, by definition, it wouldn't have been a healthy kidney.

Q. If you suspected. But sometimes isn't it a fact that you don't find out for seven or ten days until the final path report is done whether you removed a healthy organ or not?

A. In what sort of setting?

Q. Well, if you're doing oncological surgery, sometimes you're going to remove healthy organs; isn't that a fact?

A. It is. Usually that's part of your preoperative plan.

Q. And you're not saying that it's a breach of the standard of care in all cases for a healthy organ to be removed?

A. Not in all cases, no.

Tr. 136-138.

Continuing on, Dr. Roland testified:

> I mean, if you truly have a cancerous process, a malignant process that is involving sort of an innocent bystander organ that it is inseparable from, then there may be a reason to take that attached organ, or if there's an organ – for example, the example given with removing the end of the pancreas, which shares a blood supply or is intimately associated with the blood supply to the spleen, the spleen may need to come out with that organ. So they may need to be removed and sacrificed in order to remove the organ.
>
> I guess in much bigger discussion, depending on the type of cancer, whether or not there is any survival advantage to removing organs in that manner *en bloc* and doing a very large resection.
>
> So, for example, if you had a colon cancer that was eroded into numerous organs around it, there's not much of a survival benefit that's ever been shown in that patient, so you wouldn't necessarily go in and take it all out. It all depends on the scenario.[9]

Tr. 139.

[9] At this juncture, Dr. Roland was actually responding to criticism of the Respondent's use of the term operating with "impunity." Dr. Roland's point was that sometimes operating *en bloc* is necessary and that doing so – with impunity – does not mean a doctor was malicious, careless or thoughtless. The State does not allege that the Respondent removed the Patient's kidney for any of these reasons.

Thus, even Dr. Roland agrees that sacrificing a healthy organ *en bloc* is sometimes necessary. Dr. Roland takes issue with whether the Respondent had sufficient evidence of cancer. Also, Dr. Roland opined that the Respondent had options other than proceeding *en bloc*; for example, he could have terminated the surgery and brought in another physician, or referred the Patient to a tertiary hospital, consulted with the Patient's family, etc. Dr. Lin conceded that these were legitimate options, with the caveat that the existence of another option (i.e., proceeding *en bloc*) does not mean that the option the Respondent exercised was unreasonable or, more to the point, a violation of the standard of care.

In fact, the Resondent had a reasonable suspicion of malignancy based on the size of the mass, the presence of desmoplastic reaction, and the neovascularization. The fact that there was no malignancy and, moreover, the mass did not contain adrenal tissue, does not undermine the fact that the Respondent exercised reasonable professional judgment to remove the kidney *en bloc* based on all circumstances at the time. The fact that another physician may have taken a different and equally reasonable course does not mean what the Respondent did was wrong.

The State questions why the Respondent did not perform a frozen section of the adrenal mass in the first surgery before proceeding *en bloc*. Dr. Roland opined that the standard of care required a frozen section. The Respondent testified that he did not do a frozen section because the results are not always reliable and a frozen section of one part of the mass (or even of the kidney) would not have meant that there was no malignancy. More importantly, the standard of care required removing the adrenal mass, even if it was benign. Dr. Lin agrees with the Respondent.

The State questions, then, why the Respondent sent the presumed adrenal mass for a frozen section during the second surgery. In that surgery, however, the Respondent was able to dissect the entire mass and send it to pathology, where it was subjected to twelve sections,

whereas in the first surgery the mass was densely adhered to the kidney and, again, required removal even if was benign.

The State asserts that the Respondent conceded that he violated the standard of care when he admitted that he committed an error in judgment. The Respondent testified,

> [I]n surgery when we're residents, we're taught to characterize any morbidity or mortality in terms of three things: is it from patient disease, is it from an error in technique, is it an error in judgment or a combination of those three things. This is what we use to kind of classify morbidity and mortality and why it happened.
>
> So the error in judgment was taking out the wrong kidney and not taking out that mass during the first case.

Tr. 396-397. As to the mass, the Respondent clarified that his error was that he did not remove a mass seen on imaging studies.

Based on the Respondent's considerable training and experience, he believed he was removing the mass seen on the imaging studies and he needed to remove the kidney *en bloc*. He was wrong that the mass contained the adrenal gland, but he was not inexact in the performance of his duties as a surgeon, and his admission to an error in judgment is not tantamount to a violation of the standard of care. It is important to remember that the Respondent removed two masses, neither of which showed on the imaging studies and he could not have known that the masses did not harbor the adrenal gland until the tissue was sent to pathology.

The State questioned the Respondent about his written statement to the Board in which he wrote "I deeply regret these two cases. There is not a day that goes by that I do not think about these cases and what I could have done differently.... I am dedicated to ensuring that these mistakes never occur again." State Ex. 21, p.3. I do not find that the Respondent was confessing to a violation of the standard of care as to Patient B. He was expressing remorse and was conveying that he intends to learn and improve his performance, as we surely would hope from any physician.

The State argues that the Respondent was incompetent in the performance of his job because he does not know the human anatomy as evidenced by the fact that twice thought he was removing the adrenal gland but did not in either surgery. The evidence does not show that the Respondent is uneducated or unknowledgeable about anatomy. He planned to perform two adrenalectomies, complicated by various factors that I have already described. The fact that he did not remove the Patient's adrenal gland as planned, that he "failed" in the State's view, does not mean he was professionally incompetent.

The Respondent took these matters seriously enough that he subjected himself to an evaluation to see whether he is suffering from any health problems that interfere with his professional duties. The record does not show that the evaluation revealed any physical or mental health problems. The record does not therefore show that the Respondent is mentally incompetent to work as a surgeon.

While I do not find that the Respondent violated the standard of care with respect to the manner in which he performed the surgeries, I do find that he breached the standard of care by not obtaining the Patient's informed consent for the nephrectomy. The Respondent agrees that he did not discuss with Patient B the possibility of removing his kidney *en bloc* with the presumed adrenal mass because he did not anticipate the possible necessity of removing the kidney. The State does not assert that the Respondent should have anticipated that possibility. Rather, the State argues that once the Respondent realized that the adrenal mass was too densely adhered to the kidney to remove just the mass, he should have terminated the surgery.

Dr. Lin testified that the *en bloc* surgery is appropriate if there is a mutual understanding between doctor and patient. No such understanding existed between the Respondent and Patient B. The Patient had the right to make a decision about his own health. Patient B was a morbidly obese person with diabetes and other health problems, and losing a kidney is no small matter.

The Patient did not give informed consent for a nephrectomy and the Respondent had not talked to him about that possibility. It is imperative to acknowledge that the Respondent was not performing a life saving surgery on the Patient. When the Respondent found himself at a crossroads – that is, when he could not dissect the mass from the kidney – he could have stopped the surgery without endangering the Patient's life. The Patient had the right to consider his options: to obtain a second opinion, to consult with his family, to move to a tertiary care hospital, or to use another surgeon. I emphasize that it is not the fact that the Respondent removed a healthy kidney that is the determining factor, but, rather, that the Patient owned the decision to decide how to proceed.

The Patient subjected himself to a subsequent surgery with the Respondent. I infer that the Patient was satisfied with the care the Respondent offered him and perhaps he was satisfied with or accepting of the Respondent's decision to remove the kidney. How the Patient viewed the Respondent's judgment after-the-fact does not justify the Respondent's medical judgment at the time he decided to remove the Patient's kidney.

The State argues that the Respondent violated the standard of care by not dictating his operative report until ten days after Patient B's surgery. The Respondent testified that immediately following surgery, he dictated a brief surgical note that was in the Patient's medical record and he dictated his full report on February 5, 2015. He explained that he was on vacation for five days, he took time off to celebrate a holiday, and he was busy. The Respondent testified that over the course of a year, he did not timely dictate eight reports out of 600-800 cases. Based on the State's questions, I infer that it argues the Respondent acted selfishly by taking time off for the holiday and just did not care enough about his duties to dictate the report sooner. The record does not show that the Respondent is reckless or oblivious to his obligations. Rather, in this instance, based on various circumstances, he did not write the note in a timely way.

concluded that the Respondent frequently write his operative notes late. The Respondent disputes the characterization "frequently." did not quantify the lateness. The record does not show whether one late report, or even eight, out of 600-800 constitutes a violation of the standard of care. Moreover, s requirement that a doctor dictate the note within 24 to 48 hours following surgery does not set the standard of care for surgeons.

The Respondent is subject to sanction for violating the Maryland Medical Practice Act.

The Board may impose a range of penalties, from reprimand to license revocation, and a civil penalty. Md. Code Ann., Health Occ. section 14-405.1(a) (2014); COMAR 10.32.02.09B; COMAR 10.32.02.09A(3). The Board's regulations include a sanctioning matrix that reflects the minimum and maximum penalties for conduct that is subject to disciplinary action. COMAR 10.32.02.10.

The penalty for failing 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 ranges from a reprimand to revocation of the physician's license and/or a civil penalty. For failing to maintain adequate records and for violating the standard of care for Patient are, the State recommends a reprimand; a two-year probationary period during which s surgical department chief would evaluate on a monthly basis at least three of the Respondent's surgeries of the abdominal cavity; and that the chief submit quarterly reports to the Board.

The Board's regulations also identify aggravating and mitigating factors for imposing a penalty outside of the regulatory range. Mitigating factors include:

(a) The absence of a prior disciplinary record;
(b) The offender self-reported the incident;
(c) The offender voluntarily admitted the misconduct, made full disclosure to the disciplinary panel and was cooperative during the disciplinary panel proceedings;
(d) The offender implemented remedial measures to correct or mitigate the harm arising from the misconduct;

(e) The offender made good faith efforts to make restitution or to rectify the consequences of the misconduct;
(f) The offender has been rehabilitated or exhibits rehabilitative potential;
(g) The misconduct was not premeditated;
(h) There was no potential harm to patients or the public or other adverse impact; or
(i) The incident was isolated and is not likely to recur.

COMAR 10.32.02.09B(5).

The Respondent does not have a prior disciplinary history, he admitted his misconduct, he undertook an evaluation to determine whether he has a mental or physical problem that makes him unfit to work as a physician, the conduct was not premeditated, the conduct is not likely to reoccur, and the Respondent will learn from his error in judgment. The Respondent said he has taken a recordkeeping course.

Aggravating factors may include, but are not limited to, the following:

(a) The offender has a previous criminal or administrative disciplinary history;
(b) The offense was committed deliberately or with gross negligence or recklessness;
(c) The offense had the potential for or actually did cause patient harm;
(d) The offense was part of a pattern of detrimental conduct;
(e) The offender committed a combination of factually discrete offenses adjudicated in a single action;
(f) The offender pursued his or her financial gain over the patient's welfare;
(g) The patient was especially vulnerable;
(h) The offender attempted to hide the error or misconduct from patients or others;
(i) The offender concealed, falsified or destroyed evidence, or presented false testimony or evidence;
(j) The offender did not cooperate with the investigation; or
(k) Previous attempts to rehabilitate the offender were unsuccessful.

COMAR 10.32.02.09B(6). None of the aggravating circumstances are present here.

Taking all of these factors into consideration, I find that a reprimand is appropriate. The record does not establish the necessity for a more severe imposition on the Respondent's medical license.

The record does not show that the Respondent requires supervision. He was not incompetent in the performance of his duties as a surgeon and he exercised reasonable professional judgment with regard to Patient B's *en bloc* surgery. Supervision would not improve the Respondent's risk of performing wrong-side surgery.

As to recordkeeping, I recommend that the Respondent submit evidence of any recordkeeping course he has already taken to the Board for the Board to determine its sufficiency. If it is insufficient, the Respondent should enroll in and complete a recordkeeping course approved by the Board within a period set by the Board.

The State does not recommend a civil penalty and I find no cause to propose one.

If the Board determines that supervision is necessary, the State reflected upon its recommendation that Dr. Davies, as s department chief, perform that duty. The State argues that Dr. Davies is not appropriate for two reasons. First, Dr. Davies said that he did not participate in 's review of Patient B, even though his name is "plastered all over the reports." Second, the Respondent has a relationship with Dr. Davies, and the supervisor should be someone who, unlike Dr. Davies, does not have a relationship with him.

's Medical Executive Committee report or notes of March 2, 2015, list the members in attendance, including Dr. Davies. Dr. Davies testified that he was part of the wrong-side surgery discussion but not the adrenalectomy. Nothing in the report specifically states that Dr. Davies had input into a discussion or findings about the adrenalectomy. There is no evidence to refute the doctor's testimony about his participation, and I take him at his word.

Dr. Davies is a distinguished surgeon. He graduated medical school in 1961 and served a two-year internship and two-year residency at Baylor Hospital in Houston, Texas, with Dr. Michael DeBakey, the pioneering heart surgeon. He did a surgical residency with Dr. John Gibbon who performed the first open-heart operation. He spent one year at Massachusetts

General Hospital performing cardiac surgery and another year in England with Sir Ronald Belsey, a renowned thoracic cardiovascular surgeon.

Dr. Davies did two tours of duty in South Vietnam as a thoracic cardiovascular and general surgeon. After returning home from the war, he practiced thoracic cardiovascular surgery in Delaware where he eventually became the chief of thoracic surgery at Christiana Hospital, and chairman of its department of surgery for four years. After Delaware, he performed thoracic surgery at until he retired one year ago. He is board-certified in thoracic surgery and has the Royal Board in general surgery from Great Britain. He is a Fellow of the American College of Surgeons, a Fellow of the American College of Thoracic Cardiovascular Surgery and a Fellow of the American College of Cardiology. Dr. Davies has performed thousands of surgeries.

Dr. Davis first met the Respondent in 1996 or so when he was chief of surgery at Christiana Hospital in Delaware and Respondent was a new resident. They did thoracic surgery together. When Dr. Davies moved his practice from Delaware to , he and the Respondent became reacquainted. From 2006 through 2014, the Respondent assisted Dr. Davies on all thoracic surgeries Dr. Davies performed at Dr. Davies selected the Respondent to assist him because Dr. Davies knew the Respondent was experienced and well recognized.

The record does not include any evidence tending to prove that Dr. Davies would exhibit bias or a lack of skill in his supervision of the Respondent. To argue otherwise is to suggest that Dr. Davies would supervise the Respondent with the intent of protecting the Respondent and not patients. The record does not include any evidence that Dr. Davies would act to the detriment of patients. Dr. Davies and the Respondent have a rapport and the Respondent currently turns to Dr. Davies for professional consultation. For these reasons, Dr. Davies is a most suitable supervisor.

PROPOSED CONCLUSIONS OF LAW

I conclude as a matter of law that the State has not proven that the Respondent should be subject to disciplinary action on the basis that he is professionally, physically, or mentally incompetent, Md. Code Ann., Health Occ. section 14-404(a)(4); and

I further conclude as a matter of law that the State has proven that the Respondent is subject to disciplinary action on the basis that he failed 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, Md. Code Ann., Health Occ. section 14-404(a)(22); and the Respondent failed to keep adequate medical records as determined by appropriate peer review, Md. Code Ann., Health Occ. section 14-404(a)(4).

PROPOSED DISPOSITION

I **PROPOSE** that charges filed by the Board against the Respondent on the basis that he failed 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 he failed to keep adequate medical records as determined by appropriate peer review be **UPHELD**; and further,

I **PROPOSE** that charges filed by the Board against the Respondent on the basis that he is professionally, physically, or mentally incompetent be **DISMISSED**; and further,

I **PROPOSE** that the Board issue a reprimand against the Respondent and that it require the Respondent to attend a course on medical recordkeeping, unless it finds that a course the Respondent has taken in the last eighteen months is adequate.

November 21, 2016
Date Decision Issued

Laurie Bennett /RAB
Laurie Bennett
Administrative Law Judge

LB/sm
#165441

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party may file written exceptions to this proposed decision with the disciplinary panel of the Board of Physicians and request a hearing on the exceptions. Md. Code Ann., State Gov't § 10-216 (2014). Exceptions must be filed within fifteen (15) days from the date of this proposed order. COMAR 10.32.02.05B(1). The exceptions and request for hearing must be addressed to the disciplinary panel of the Board of Physicians, 4201 Patterson Avenue, Baltimore, MD, 21215-2299, Attn: Christine A. Farrelly, Executive Director.

A copy of the exceptions should be mailed to the opposing attorney, and the opposing party will have fifteen (15) days from the filing of exceptions to file a written response. *Id.* The response must be addressed as above. *Id.* The Office of Administrative Hearings is not a party to any review process.