IN THE MATTER OF	*	**BEFORE THE MARYLAND**
THOMAS J. RALEY, M.D.	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D68746	*	**Case Number: 2220-0214**

* *

CONSENT ORDER

PROCEDURAL BACKGROUND

The Maryland Board of Physicians (the "Maryland Board") received information that Thomas J. Raley, M.D., (the "Respondent") License Number D68746, was disciplined by the Virginia Board of Medicine (the "Virginia Board"). By Order dated December 5, 2019, the Respondent was reprimanded.

Based on the above referenced Virginia Board sanction, the Maryland Board has grounds to charge the Respondent with violating the following provisions of the Maryland Medical Practice Act (the "Act"), under H. O. § 14-404(a):

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> > (21) Is disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or disciplined by any branch of the United States uniformed services or the Veteran's Administration for an act that would be grounds for disciplinary action under this section,

The Maryland Board has determined that the acts for which the Respondent was disciplined in Virginia would be grounds for disciplinary action under H.O. § 14-404(a) (3ii) and (40) the ground for disciplinary action under H.O. § 14-404(a) is as follows:

(3ii) Is guilty of unprofessional conduct in the practice of medicine.

(40) Fails to keep adequate medical records as determined by appropriate peer review.

Based on the action taken by the Virginia Board, the Respondent agrees to enter into this Consent Order with the Maryland Board of Physicians, consisting of Procedural Background, Findings of Fact, Conclusions of Law, and Order of reciprocal action.

I. FINDINGS OF FACT

The Board finds the following:

1. At all times relevant hereto, the Respondent was a physician licensed to practice medicine in the State of Maryland. The Respondent was initially licensed in Maryland on or about February 27, 2009.

2. By Order dated December 5, 2019, the Virginia Board found the Respondent improperly delegated a female patient's care to and failed to appropriately supervise the care rendered to the patient by a physician assistant.

3. The Virginia Board further found the Respondent failed to keep timely, accurate and complete medical records for multiple patients.

A copy of the Virginia Board Order is attached hereto.

II. CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Maryland Board concludes as a matter of law that the disciplinary action taken by the Virginia Board against the Respondent was for an act or acts that would be grounds for disciplinary action under Health Occ. § 14-404(a)(3ii) and (40) had those offenses been committed in this state, and would thus subject him to discipline under Health Occ. §14-404(a)(21).

III. ORDER

It is hereby:

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

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

03/04/2020
Date

Signature on File

Christine A. Farrelly
Executive Director
Maryland Board of Physicians

CONSENT

I, Thomas J. Raley, M.D. assert that I am aware of my right to consult with and be represented by counsel in considering this Consent Order and in any proceedings that would otherwise result from the charges currently pending. I have chosen to proceed without counsel and I acknowledge that the decision to proceed without counsel is freely and voluntarily made.

By this Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition.

I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 14-405 and Md. Code Ann., State Gov't §§ 10-201 et seq. concerning the pending charges. I waive this right and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive

protections. I acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order.

I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.

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

Signature on File

2/26/20
Date

Thomas J. Raley, M.D.
Respondent

NOTARY

STATE OF Maryland

~~CITY~~COUNTY OF Harford

I HEREBY CERTIFY that on this 26 day of February 2020, before me, a Notary Public of the State and City/County aforesaid, personally appeared Thomas J. Raley, M.D. and made oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS my hand and notarial seal.

V Rosalie Brandow
Notary Public

My Commission expires: 8/29/21

V. ROSALIE BRANDOW NOTARY PUBLIC HARFORD COUNTY, MD

BEFORE THE VIRGINIA BOARD OF MEDICINE

IN RE: THOMAS JOHN RALEY, JR., M.D.
License Number: 0101-243103
Case Number: 156912

ORDER

JURISDICTION AND PROCEDURAL HISTORY

Pursuant to Virginia Code §§ 2.2-4019 and 54.1-2400(10), a Special Conference Committee of the Virginia Board of Medicine ("Board") held an informal conference on November 20, 2019, in Henrico County, Virginia, to inquire into evidence that Thomas John Raley, Jr., M.D., may have violated certain laws and regulations governing the practice of medicine and surgery in the Commonwealth of Virginia.

Thomas John Raley, Jr., M.D., appeared at this proceeding and was represented by Ashley Calkins, Esquire.

Upon consideration of the evidence, the Committee adopts the following Findings of Fact and Conclusions of Law and issues the Order contained herein.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Thomas John Raley, Jr., M.D., was issued License Number 0101-243103 to practice medicine and surgery on February 22, 2008, which is scheduled to expire on January 31, 2020. At all times relevant to the findings contained herein, said license was current and active.

2. Dr. Raley violated Virginia Code § 54.1-2915(A)(18) and 18 VAC 85-20-26(C) and 18 VAC 85-20-29(A)(1) of the Regulations Governing the Practice of Medicine ("Regulations") in the care and treatment of Patient A, a 31-year-old female whom he treated in 2010-2011 for complaints of back and left leg pain. Specifically:

a. Dr. Raley improperly delegated Patient A's care to and failed to appropriately supervise the care rendered to Patient A by Physician Assistant 1. For example:

i. At her first office visit at Dr. Raley's practice on December 14, 2010, Patient A was seen by Physician Assistant 1, who had been working as a physician assistant for approximately one year. At the appointment, Physician Assistant 1 diagnosed Patient A with lumbago and lumbar radiculitis, prescribed pain medication (fentanyl (C-II) transdermal patches and tramadol), and recommended a caudal epidural injection. At Patient A's next appointment, on January 6, 2011, by his own admission Dr. Raley performed the caudal epidural injection without examining the patient himself. At her follow up appointment, on January 25, 2011, the patient was again seen by Physician Assistant 1.

ii. At an office visit on April 25, 2011, Physician Assistant 1 reviewed Patient A's spinal MRI and discussed trying another caudal epidural injection to treat her continuing back pain. Physician Assistant 1 documented discussing "if the caudal does not significantly improve the patient's pain she could consider continuing medication versus surgery. I discussed decompression versus spinal cord stimulator." Other than the epidural injection performed by Dr. Raley in early January, Patient A had been seen at the practice exclusively by Physician Assistant 1, and there is no indication in the chart that Dr. Raley had reviewed the MRI, examined Patient A, or discussed the patient's course of treatment with Physician Assistant 1.

iii. At an office visit on May 5, 2011, Physician Assistant 1 again discussed surgical options with Patient A and recommended a lumbar interlaminar injection "prior to surgery to help diagnose the cause of the symptoms." As of that date, Patient A had not been examined by Dr. Raley and there is no indication in the chart that he reviewed her MRI or had discussed her treatment plan with Physician Assistant 1.

iv. Patient A was treated by Physician Assistant 1 for her complaints of ongoing back and groin/leg pain on or about 1/25/11, 2/22/11, 4/25/11, 5/5/11, 5/27/11, 6/21/11, and 7/19/11 without being seen or examined by Dr. Raley every fourth office visit for a continuing illness, as required by 18 VAC 85-50-110(1)[1] of the Regulations Governing the Practice of Physician Assistants. Moreover, progress notes authored by Physician Assistant 1 indicate that she conducted cursory reviews of systems and performed minimal to no physical examinations of the patient during said office visits, although during this period she prescribed approximately 360 dosage units of oxycodone (C-II), 60 dosage units of MS Contin (morphine, C-II), and 720 dosage units of tramadol to Patient A.

v. Progress notes dated September 13, 2011, state that Dr. Raley "talked about L4-S1 fusion surgery" with Patient A at that office visit, but that they would "discuss surgical options... after x-rays." At her next office visit, on October 4, 2011, Patient A returned with lumbar x-rays showing "Mild degenerative changes centered at L5-S1." While noting that the x-rays did not include flexion and extension views, Physician Assistant 1 documented that she would request insurance authorization for lumbar fusion, and she instructed Patient A to return for a pre-op visit the following month. There is no indication in the chart that Physician Assistant 1 consulted with Dr. Raley before recommending spine surgery to Patient A at this office visit.

[1] Subsection 1 of this regulation was revised effective July 3, 2013.

vi. When Patient A returned for an office visit on October 18, 2011, she was again seen by Physician Assistant 1, who reviewed new flexion/extension lumbar x-rays and concluded they showed spondylolisthesis at L4-L5 with 3-4mm change on flexion and extension. At that office visit, Physician Assistant 1 again recommended surgery to Patient A and noted that she was requesting insurance authorization for L4-S1 fusion surgery, although the radiologist who reviewed the x-rays reported no spondylolysis or spondylolisthesis. There is no indication in the chart that Physician Assistant 1 consulted with Dr. Raley or the radiologist regarding the differences in interpretation of the flexion/extension x-rays prior to recommending L4-S1 fusion to Patient A at this office visit.

b. Dr. Raley failed to keep timely, accurate, and complete medical records regarding Patient A's treatment. Specifically:

i. Patient A's chart at Dr. Raley's practice is missing hard copies of fluoroscopic imaging from her January 6, 2011 epidural injection, although Dr. Raley documented obtaining a hard copy of an image to confirm correct placement of the needle in the epidural space.

ii. Patient A's electronic medical records ("EMR") from Dr. Raley's practice repeatedly carried over incorrect entries. For example, at multiple office visits the review of systems listed "no lower back pain" and "no sciatica," although Patient A was diagnosed with sciatica, and "no tingling/numbness," although she repeatedly reported such symptoms in her left leg. Likewise, under "physical examination," the patient's body habitus is listed as normal, although she was morbidly obese. Moreover, progress notes from the November 11, 2011 office visit with Dr. Raley indicated that Patient A's medication regimen included Ativan, Lyrica, Tramadol, and Opana, although she had not been prescribed Ativan or Lyrica since May, tramadol since July, and Opana since September.

iii. By Dr. Raley's own admissions made under oath, his documentation of Patient A's office visits was inaccurate or incomplete. For example:

- Progress notes from office visits Patient A had with Dr. Raley on August 16, 2011 and September 13, 2011 state that her physical examination, including neurological exam, was "normal" on each date, although Dr. Raley subsequently explained that she had positive findings of pain in her back radiating down to her left leg, occasional pain in her neck, tenderness in the buttocks, and weakness in her left lower extremity.

- Progress notes from the November 11, 2011 office visit documented pain only at the left L5-S1 area, although Dr. Raley subsequently explained this was inaccurate.

- Progress notes from the November 29, 2011 office visit documented a normal musculoskeletal system, although Dr. Raley subsequently stated that the record should have included complaints of back pain, sciatica, muscle pain, and muscle weakness. Additionally, Dr. Raley subsequently stated that he failed to

accurately document the patient's neurological examination, in that he did not indicate a change in sensation to light touch at her left lower extremity as compared to the contralateral side, and he failed to indicate pain on palpation and positive straight leg raise on the left side. Dr. Raley also stated that for the musculoskeletal exam he failed to note that muscle testing showed weakness in the patient's great toe. These details were reported by Dr. Raley during a civil deposition approximately five years after the office visits in question.

iv. Dr. Raley did not dictate his operative report for Patient A's December 19, 2011 spine surgery until January 18, 2012, and he failed to include in the report any explanation for the delay. Additionally, he did not electronically sign the report until February 27, 2012.

v. Dr. Raley dictated his operative report from Patient A's December 27, 2011 surgical sponge-removal surgery the day after surgery, but he did not electronically sign it for approximately two months (February 27, 2012).

3. Dr. Raley violated Virginia Code § 54.1-2915(A)(18) and 18 VAC 85-20-26(C) of the Regulations in that he failed to keep timely, accurate, and complete medical records for Patients B-F, as follows:

- Patient B's chart from Dr. Raley's practice is missing hard copies of fluoroscopic images which progress notes indicate were taken during injection procedures performed on December 21, 2012 (caudal epidural injection), March 15, 2013 (lumbar epidural steroid injection), and July 15, 2013 (lumbar bilateral medial branch blocks).

- Dr. Raley dictated his operative report the same day as Patient B's spinal fusion surgery on October 28, 2013; however, he did not electronically sign it until November 18, 2013. On November 18, 2013, without explanation Dr. Raley dictated a second operative report for the same surgery, although that report is missing the procedure date.

- Dr. Raley did not dictate his operative report from Patient B's October 30, 2013 incision and debridement procedure for 86 days (until January 24, 2014), and the report did not include the procedure date. In the report, Dr. Raley indicated that "The patient after [the October 28th fusion] surgery was fine," despite the fact that other providers' notes indicate she began to exhibit signs of delirium shortly after coming out of anesthesia. Additionally, it is not clear from the operative report that while the patient was in the OR for the I&D procedure, Dr. Raley also performed a laminectomy, although in his written statement to the Board's investigator (submitted in July 2014), he stated that "A laminectomy was done above the fusion site at L3."

- Dr. Raley did not dictate an operative report from the December 9, 2013 procedure to explore Patient C's sciatic nerve for two weeks, until December 23, 2013. The operative report did not include the date of the patient's recent hip replacement, or the fact that she required transfusions during the sciatic nerve exploration. When requested by the hospital to address several items missing or unclear in the operative report,

including that the patient's "Treatment included 3 units PRBC," Dr. Raley's addendum noted that "2 units of blood was transfused."

- Dr. Raley did not dictate his operative report from Patient D's November 4, 2013 spine surgery for two weeks, until November 18, 2013. In the report he referred to the procedure as L5-S1 PLIF with instrumentation; however, approximately six months later, on April 4, 2014, he dictated an addendum stating that all mentions in the original report to L5-S1 should be changed to L4-S1. Moreover, Dr. Raley did not electronically sign the addendum for 17 days, until April 21, 2014.

- In Dr. Raley's operative report from revision spine surgery that he performed on Patient D on January 17, 2014, he documented removing the left L4 pedicle screw. Approximately three months later, on April 4, 2014, he dictated an addendum correcting the description of the procedure to "removal of left L5 pedicle screw." Dr. Raley did not electronically sign this addendum until 17 days after he dictated it, on April 21, 2014.

- Dr. Raley did not dictate the transfer summary (for continuing care related to Patient E's October 7, 2013 lumbar surgery) until 17 days after discharge (October 28, 2013), and he did not electronically sign the transfer summary until 38 days after discharge (November 18, 2013).

- Dr. Raley did not dictate his operative report from Patient F's October 28, 2013 cervical spine surgery for 50 days (December 17, 2013).

4. At the informal conference, Dr. Raley led the Committee through his complication rates from six sites at which he does surgery. Statistics from Stafford Hospital -- where the surgeries for Patients A-F had been performed -- were not included, since he no longer performs surgery there. Dr. Raley stated that his recent complication rates do not indicate that he is an outlier by local or national standards.

5. Dr. Raley stated to the Committee that he has not had the complication of foot drop since 2013, when Patients B, C, and E exhibited this post-surgical complication.

6. At the informal conference, the Board's expert and Dr. Raley's expert addressed Dr. Raley's patient selection and the standard of care for each of the patients in the Notice.

7. Dr. Raley stated to the Committee that imaging for the patients at issue taken at his practice during office visits had been lost from the practice's EMR system. He reported that the

practice has a new EMR and that they now save all imaging in a HIPAA-compliant manner to the cloud.

8. Dr. Raley stated to the Committee that he has learned from his experiences with the patients at issue, and that he now takes documentation more seriously and is more detailed in his recordkeeping.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Virginia Board of Medicine hereby ORDERS that Thomas John Raley, Jr., M.D., is REPRIMANDED.

Pursuant to Virginia Code §§ 2.2-4023 and 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD

[redacted]

for William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 12/5/19

NOTICE OF RIGHT TO APPEAL

Pursuant to Virginia Code § 54.1-2400(10), you have 30 days from the date you are served with this Order in which to notify William L. Harp, M.D., Executive Director, Board of Medicine, 9960Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that you desire a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall vacated. The service date shall be defined as the date you actually received this decision or the date it was mailed to you, whichever occurred first. In the event this decision is served upon you by mail, three days are added to that period.