IN THE MATTER OF	*	**BEFORE THE**
PATRICIA MALTAGLIATI, PA-C	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: C01881	*	**Case Number: 2015-0889A**

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CONSENT ORDER

On November 3, 2017, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board"), charges **PATRICIA MALTAGLIATI, PA-C** (the "Respondent"), License Number C01881, under the Maryland Physician Assistants Act (the "Act"), Md. Code Ann., Health Occ. II §§ 15-314.

The pertinent provisions of the Act provide:

> (a) *Grounds.* -- Subject to the hearing provisions of § 15-315 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum, may reprimand any physician assistant, place any physician assistant on probation, or suspend or revoke a license if the physician assistant:
>
> (3) Is guilty of: (ii) unprofessional conduct in the practice of medicine;
>
> (22) Fails to meet appropriate standards 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/or]
>
> (40) Fails to keep adequate medical records[.]

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

I. FINDINGS OF FACT

Panel A finds:

1. The Respondent is a physician assistant. The Respondent was initially licensed by the Board on March 18, 1997. The Respondent's license is scheduled to expire on June 30, 2019.
2. At all times relevant to these charges, the Respondent was a physician assistant at a group medical practice with multiple locations in Maryland specializing in primary care/urgent care (Practice A).[1]
3. On June 12, 2015, the Respondent submitted an Application for Renewal of Physicians Assistant License ("Application").
4. In her Application, the Respondent answered "YES" to the following question:

   > Has your employment by any health care employer been affected by disciplinary actions including probation, suspension, loss or limitation of privileges, reprimand, transfers to other duties or termination of employment of contact?

5. As part of the Application, the Respondent was required to provide a brief explanation of the question in ¶4. The Respondent wrote that she was "terminated for being late."
6. On July 10, 2015, the Board was notified that the Respondent's delegation agreement was terminated on March 23, 2015. According to the Termination of Employment (Delegation Agreement) Report, the Respondent was terminated from Practice A "due to performance and time and attendance."
7. As a result, the Board initiated an investigation.
8. The Board notified the Respondent of its investigation, requested a written response from the Respondent and subpoenaed the Respondent's personnel records from Practice A.

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[1] To ensure confidentiality, the names of individuals, patients, and institutions involved in this case are not disclosed in this document. The Respondent may obtain the identity of all individuals, patients, and institutions referenced in this document by contacting the administrative prosecutor.

9. In both the Respondent's written response to the Board, and during her interview with Board staff on April 7, 2016, the Respondent admitted that in addition to issues with persistent tardiness,[2] "there were concerns as to how [the Respondent] expressed [herself] to staff, management and patients." The Respondent stated that she was counseled by her supervisor regarding both issues.

10. As part of her employment agreement at Practice A, the Respondent signed an acknowledgement that "several of [the Respondent's] references" noted concerns with the Respondent's bedside manner, specifically "they described a manner of communication which lacked empathy and . . . lacking sympathy for patients' concerns." The agreement further noted that any patient complaint may result in immediate termination from Practice. A. The Respondent signed the agreement on November 8, 2013.

11. During the Respondent's employment at Practice A, the Respondent was counseled formally on several occasions regarding her demeanor during patient interactions and with colleagues.

12. On May 6, 2014, as part of the Respondent's performance review, the Respondent's supervisor indicated that the Respondent has had a "number of [] complaints, primarily related to bedside manner." The Respondent was counseled that she must make "immediate improvement in patient satisfaction scores."

13. On February 11, 2015, the Practice A counseled the Respondent regarding complaints from colleagues and staff that the Respondent came to work "with a negative attitude."

14. On March 17, 2015, Practice A counseled the Respondent regarding a patient complaint that the "provider was rude, condescending, and appeared to not like other people." Practice A noted this was her "Final Warning."

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[2] Personnel records show that the Respondent was tardy on 40 occasions from November 28, 2014 to March 17, 2015.

15. Practice A terminated the Respondent on March 20, 2015.

16. In furtherance of its investigation, the Board subpoenaed six patient medical records and summaries of care (Patients 1-6) from the Respondent and transmitted the records along with the summaries of care, and other relevant records, for a peer review by a licensed physician assistant.

17. On or about September 2, 2016, the Board received the peer review report, the results of which are set forth in pertinent part below.

PATIENT-RELATED ALLEGATIONS

PATIENT 1

18. Patient 1, a 12-year-old male, presented to Practice A for head trauma after Patient 1 was hit in the head with a rock. The Respondent saw Patient 1 on one occasion, on the date of the injury. Patient 1 suffered from a 2-cm laceration to the anterior scalp. The Respondent diagnosed Patient 1 with a concussion without loss of consciousness.

19. The Respondent failed to palpate Patient 1's skull to rule out a fracture.

20. The Respondent failed to document the treatment of the scalp laceration, *i.e.* whether the Respondent used a bandage or staples in her treatment of Patient 1. During her interview with Board staff, the Respondent was unable to recall what treatment was rendered.

21. The Respondent failed to document a full description of the scalp laceration, including the depth of the laceration.

22. The mother of Patient 1 complained to Practice A that she was not given appropriate discharge instructions by the Respondent regarding the diagnosis of concussion. Specifically, Patient 1's mother complained that she was not told that Patient 1 had suffered a concussion and should rest. There is no documentation in Patient 1's record regarding specific

concussion discharge instructions or documentation that the family understood the discharge instructions.

PATIENT 2

23. Patient 2, a six-year-old male, was seen by the Respondent with a multiple week history of acute, severe, intermittent stomach pain. Patient 2's surgical history was positive for hernia repair.
24. The Respondent's treatment failed to meet the standard of quality care. The Respondent failed to consider the possibility that constipation, one of the most common causes of abdominal pain in children, was the cause. There is no evidence the provider questioned bowel activity, oral intake, or urine output.
25. The Respondent failed to document negative or positive hernias on the examination of Patient 2, despite Patient 2's previous hernia history.
26. The Respondent failed to consider the import that the symptoms were intermittent and severe when they occurred.
27. The Respondent failed to perform diagnostic studies, or failed to document why they were not necessary, in identifying possible emergent causes of the abdominal pain.
28. The Respondent failed to consider and/or discuss with the family serial abdominal examinations.
29. Patient 2's mother submitted a complaint to Practice A regarding her experience with the Respondent.

PATIENT 3

30. Patient 3, a female in her early 30s, was treated by the Respondent on January 29, 2014. Patient 3 presented to Practice A with a two-week history of a left earache and increasing

nasal congestion. The physical examination was positive for inability to visualize the tympanic membranes and ceruminous ear canals.

31. Manual cerumen removal is indicated for patients with symptoms due to cerumen. The Respondent failed to document in Patient 3's medical record whether she performed, or attempted to perform, a manual removal. Patient 3, however, submitted a complaint to Practice A regarding the Respondent's treatment, including a description of the Respondent's attempt at a manual removal. Patient 3's complaint details that the procedure was stopped when blood was noted. The medical record for Patient 3 lacked complete documentation of the procedures performed. The medical record provides no documentation about specific difficulty with the ear irrigation, other than an inability to remove the cerumen due to the patient's inability to tolerate the procedure.

32. In the Respondent's interview with the Board, the Respondent testified that she referred Patient 3 to a specialist, but the medical record reveals that the Respondent referred Patient 3 to her primary care provider.

PATIENT 5

33. Patient 5, a female in her early 60s, was treated by the Respondent at Practice A for a sore throat on April 12, 2014. Patient 5 was previously seen by a different provider at Practice A approximately a month prior, and was diagnosed with strep pharyngitis. When seen by the Respondent, she complained of a three-day history of worsening difficulty swallowing and worsening sore throat. The rapid step test was negative, and Patient 5 was treated for pharyngitis.

34. The Respondent met the appropriate standard of care with the treatment of Patient; however, Patient 5 submitted a complaint regarding the Respondent's bedside manner. Communication

skills and bedside manner are components of the Respondent's overall rendering of care. Patient 5 wrote to Practice A that the interaction with the Respondent "was not a positive one." Patient 5 wrote that she had difficulty speaking as a result of her sore throat, but that the Respondent responded inappropriately when Patient 5 "didn't answer quickly or correctly."

PATIENT 6

35. Patient 6, a female in her late 50s, was treated by the Respondent at Practice A for congestion. Patient 6 was seen two days prior, by a different provider at Practice A for a fever, sore throat, cough and cold. No prescriptions were given to Patient 6 at the first visit. At Patient 6's second visit, Patient 6 complained to the Respondent that her symptoms had worsened. Patient 6 had an allergy history which included anaphylaxis from ampicillin. The Respondent diagnosed Patient 6 with bronchitis.
36. The Respondent offered Patient 6 a nebulizer and antibiotics. Although literature recommends not treating bronchitis with antibiotics, as this was the second visit and Patient 6's symptoms had worsened, the Respondent's treatment in this regard was reasonable.
37. The Respondent, however, initially tried to prescribe amoxicillin despite documentation in the record that Patient 6 had an anaphylactic reaction to ampicillin. This is a significant breech in the standard of care. Patient 6 declined the prescription.
38. Patient 6's daughter, who was with Patient 6 at visit, complained to Practice A regarding the care the Respondent provided. She described the Respondent as very rude and stated that the Respondent spoke disrespectfully to Patient 6. She noted that the antibiotic that the Respondent offered could cause Patient 6 to have an allergic reaction.

II. CONCLUSIONS OF LAW

Based on the Findings of Fact, Panel A concludes as a matter of law that the Respondent's conduct constitutes violations of Health Occ. II § 15-314(a)(22) and (40). The charge of Health Occ. II § 15-314(a)(3)(ii) was dismissed.

III. ORDER

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

ORDERED that the Respondent's license is **REPRIMANDED;** and it is further

ORDERED that the Respondent is placed on **PROBATION** with the following conditions:

> a. Within SIX (6) MONTHS, the Respondent shall successfully complete a Board disciplinary panel-approved course in **Medical Documentation**. The Panel will not accept a course taken over the internet. The course may not be used to fulfill the continuing medical education credits required for license renewal. The Respondent must provide documentation to the Board that the Respondent has successfully completed the course;
> b. Within SIX (6) MONTHS, the Respondent shall successfully complete a Board disciplinary panel-approved course in **Professionalism/Communication**. The Panel will not accept a course taken over the internet. The course may not be used to fulfill the continuing medical education credits required for license renewal. The Respondent must provide documentation to the Board that the Respondent has successfully completed the course; and it is further

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

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

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

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

ORDERED that, after the appropriate hearing, if the Board or Disciplinary Panel determines that the Respondent has failed to comply with any term or condition of this Consent Order, the Board or Disciplinary Panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice medicine in Maryland. The Board or Disciplinary Panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

ORDERED that the Respondent shall comply with all laws governing the practice of medicine under the Maryland Physician Assistants Act and all rules and regulations promulgated thereunder; and it is further

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., Gen. Prov. §§ 4–101 *et seq.* (2014 & Supp. 2015)

01/29/2018
Date

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

CONSENT

I, Patricia Maltagliati, PA-C, by affixing my signature hereto, acknowledge that:

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

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

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

1/29/2018
Date

Patricia Maltagliati, PA-C
Patricia Maltagliati, PA-C

STATE/ DISTRICT OF Baltimore County, MD

CITY/COUNTY OF:

I HEREBY CERTIFY that on this 29 day of January, 2018, before me, a Notary Public of the State/District and County aforesaid, personally appeared Patricia Maltagliati, PA-C, and gave oath in due form of law that the foregoing Consent Order was her voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Notary Public

My commission expires: 4/5/2020