IN THE MATTER OF	*	BEFORE THE MARYLAND
BARRY PORTNER, M.D.,	*	STATE BOARD OF PHYSICIAN
Respondent.	*	QUALITY ASSURANCE
License Number: D 09675	*	Case Numbers: 96-0480 and 97-0512

* * * * * * * * * * *

FINAL ORDER

PROCEDURAL HISTORY

a. Charges

On December 17, 1997, the Maryland State Board of Physician Quality Assurance (the "Board") filed charges against the Respondent, Barry Portner, M.D. (Dr. Portner) for violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("HO"), §§ 14-401 et seq. (Supp. 1999). Specifically, the Board issued charges against Dr. Portner for: (1) rendering substandard medical care to two patients[1] for whom he provided obstetrical care; and (2) for engaging in immoral or unprofessional care in the practice of medicine, in violation of HO §§ 14-404(a)(3) and (22). This statute provides as follows:

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (3) Is guilty of immoral or unprofessional conduct in the practice of medicine;
>
> (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.

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[1]For purposes of confidentiality, these two patients will not be identified by name, but will be referred to as Patients A and B throughout this Final Order.

These charges ultimately led to an evidentiary hearing held on June 8 through June 12 and on June 15, 1998 at the Office of Administrative Hearings before Guy J. Avery, Administrative Law Judge, pursuant to Md. Code Ann., HO § 14-405(a).

b. First Proposed Decision

On September 23, 1998, the Administrative Law Judge issued a Proposed Decision. In this Proposed Decision, the Administrative Law Judge found that Dr. Portner violated the standard of care with respect to Patient A in numerous ways following the birth of Patient A's hydrocephalic twin, and that he was guilty of unprofessional conduct by his substandard and unorthodox procedures and by his "intentionally attempting the fetal demise of a viable infant during delivery." With respect to Patient B, the Administrative Law Judge found that the evidence was not clear and convincing that Dr. Portner had violated the standard of care; he proposed that the charges filed by the Board with respect to Patient B be dismissed.

The Administrative Law Judge recommended revocation of Dr. Portner's license to practice medicine in the State of Maryland. Both the State and Dr. Portner filed with the Board written Exceptions to the Administrative Law Judge's September 23, 1998 Proposed Decision.

c. First Exceptions Hearing and Board Remand

On October 9, 1998, Dr. Portner filed with the Board a Motion to Remand along with written Exceptions. With that motion, he attached an affidavit from a physician, Dr. Karin Blakemore, who was not called as a witness at the hearing. The affidavit disputed a

statement attributed to her in State's Exhibit 20W, a statement to the effect that Dr. Portner had told this physician that he "planned to cause the death" of Patient A's hydrocephalic twin.

After a hearing before the Board on both parties' Exceptions and on Dr. Portner's Motion to Remand, the Board issued an Interim Order on December 30, 1998, in which it adopted the findings of fact and conclusions of law of the Administrative Law Judge with respect to Patient B, and, accordingly, dismissed the charges issued by the Board in case number 97-0512 regarding Patient B.

With respect to Patient A, the Board granted a limited remand for the purpose of allowing Dr. Portner to present the testimony of Dr. Blakemore, and for the Administrative Prosecutor to present any rebuttal testimony.[2] The Board stated, however, that it was primarily interested in the quality of medical care that Dr. Portner provided and in the clinical and consultative history of the case, and that his alleged intent to cause the death of Patient A's hydrocephalic twin, though relevant, should not be the main focus of the decision.

d. Proposed Decision on Remand

A remand hearing was held on June 21, 1999, before the same Administrative Law Judge that issued the September 23, 1998 Proposed Decision. At the remand hearing, Dr. Portner's proffered witness, Dr. Blakemore, testified, as did Nayna Duff Campbell

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[2]The Board did note that: "Ordinarily, the failure to contact a declarant of a statement which [the attorney knows] will be moved into evidence is not a sufficient reason for remand. Likewise, a calculated decision not to call a witness, or not to present certain evidence, does not constitute a sufficient ground for remand -- even if the newly-proffered testimony would possibly change the decision reached." Interim Order of December 30, 1998, p. 3. "Second thoughts on the part of either party with respect to what to investigate, or which strategies to pursue, do not generally justify a remand." Id.

Philipsen, Board Investigator. One additional document was admitted into evidence -- the resume of Nayna Duff Campbell Philipsen.

On September 13, 1999, the Administrative Law Judge issued a Proposed Decision on Remand incorporating all of the testimony and other evidence which had been submitted at the first hearing in June 1998. In that decision, the Administrative Law Judge: (1) discussed at great length the additional evidence provided at the remand hearing; (2) incorporated all of the findings of fact and conclusions of law as set forth in the original September 23, 1998 Proposed Decision; (3) made one additional finding of fact that "Dr. Blakemore informed [Dr. Portner] that Twin A could very well survive and be a long-term survivor, despite the possibility of major handicaps"; (4) responded to various arguments raised by Dr. Portner; and (5) recommended again that Dr. Portner's license to practice medicine in the State of Maryland be revoked.

e. Second Exceptions Hearing

Dr. Portner filed Exceptions to the Administrative Law Judge's September 13, 1999 Proposed Decision on Remand, and a second Exceptions hearing was held before the Board on December 15, 1999. Dr. Portner excepted to the Administrative Law Judge's conduct of the remand hearing, and to numerous findings of fact and credibility determinations made by the Administrative Law Judge as a result of the remand hearing.

The Board disagrees with Dr. Portner's contention that the Administrative Law Judge violated the Interim (Remand) Order. That Order did not require, nor even suggest, that Dr. Blakemore could be called as an expert witness on the ultimate facts of the case. The Order specifically allowed Dr. Blakemore to be called on remand in order to: (1) dispute a factual statement attributed to her in State's Exhibit 20W; and (2) provide her testimony concerning the earlier clinical and consultative history of the case. This is testimony on

factual issues. The Administrative Law Judge followed the Board's Interim Order correctly and even allowed Dr. Portner an additional advantage by allowing Dr. Blakemore to express some medical opinions. Dr. Portner's exception, that he was not allowed "the full benefit of the Remand Order," is incorrect and is rejected. Dr. Portner's remaining exceptions go almost exclusively to the weight of the evidence. The Board, however, agrees with the Administrative Law Judge's weighing of the evidence as set forth in the September 13, 1999 Proposed Decision on Remand.

After considering the entire record in this case, including the record made before the Administrative Law Judge at the initial June 1998 hearing and also at the June 1999 Board-ordered Remand Hearing, all of the written Exceptions and responses filed by both parties, and both hearings held before the Board on these Exceptions, the Board issues this Final Order.

FINDINGS OF FACT

The Board adopts the Administrative Law Judge's Proposed Findings of Fact as set forth in the September 23, 1998 Proposed Decision and in the September 13, 1999 Proposed Decision on Remand as its own with the exception noted in footnote 3.[3] The Board finds that these facts have been proven by clear and convincing evidence. (The Administrative Law Judge's Proposed Decision of September 23, 1998 and Proposed

[3]The Board disavows the Administrative Law Judge's findings that Dr. Portner attempted to cause the demise of Patient A's hydrocephalic infant, as Dr. Portner was not charged with such an intent. (See Interim Order at page 4.) In Finding of Fact number 19 of the September 23, 1998 Proposed Decision, the Administrative Law Judge found that "[Dr. Portner's] plan was to first deliver Twin B, then cause the death of Twin A." The Board rejects this Finding of Fact. The Board does not, however, disagree with the Administrative Law Judge's subsidiary factual findings that include statements Dr. Portner made to others about his intentions. See, e.g., Proposed Decision dated September 23, 1998, Findings of Fact numbers 18, 20, 42, 48, 53, and 54.

Decision on Remand of September 13, 1999 is incorporated by reference into this Final Order and are attached as Appendix A and B respectively.) These findings will be summarized below.

In May 1995, Dr. Portner began providing obstetrical care to Patient A, then 37 years old. Patient A had been Dr. Portner's patient for about 18 or 19 years and he had delivered Patient A's other two children. Dr. Portner determined that Patient A had a twin pregnancy and that one twin was affected by hydrocephalus. Dr. Portner referred Patient A to the Division of Maternal-Fetal Medicine at Johns Hopkins Hospital for further obstetrical care and counseling with Dr. Karin Blakemore, a Geneticist and a specialist in Maternal-Fetal Medicine at Johns Hopkins Hospital.

From October 25, 1995 -November 8, 1995, Dr. Blakemore followed Patient A's prenatal care, but Dr. Portner continued to provide office obstetrical care to Patient A. Dr. Blakemore and Dr. Portner discussed Patient A's pregnancy on a number of occasions. Because the twins were identical, Dr. Blakemore recommended to Dr. Portner that no in utero procedures be done; that is, no shunt should be placed in Twin A, and there should be no attempt at selective reduction. In addition, Dr. Blakemore informed Dr. Portner that Twin A could survive and be a long-term survivor despite the possibility of major handicaps.

On November 23, 1995, Dr. Portner admitted Patient A to the labor and delivery unit at Franklin Square Hospital. Patient A was at thirty-five weeks gestation. Dr. Portner had a sonogram done while he and his assistant, Chief Resident Dr. Peggy Fletcher, scrubbed for surgery. The sonogram showed that both babies were in a transverse position with Twin B in the higher position in the fundus of the uterus. Dr. Portner performed a cesarean section operation using a classical incision and delivered Twin B, the non-hydrocephalic twin. After Twin B was delivered, Dr. Portner asked for a spinal needle and a 20cc syringe

and ordered the Chief Resident, Dr. Fletcher, to insert the needle in Twin A's head to do a cephalocentesis. Dr. Fletcher drew off only 20cc of fluid and a second attempt to draw off more fluid was unsuccessful. There was no medical justification for this cephalocentesis at this point and the cephalocentisis was not properly performed. A sonogram was not done, only 20cc of fluid was removed, and apparently no additional needles were available when the first one became clogged.

Dr. Portner then delivered Twin A and held only the head and shoulders of Twin A outside of Patient A's body for about two or three minutes before delivering the rest of Twin A's body. During this period of "half-delivery," and also while Twin A lay on the mother's abdomen, Twin A was covered with a towel or drapery of some sort. Twin A was left on the mother's abdomen for a longer than usual period of time. During the time that Twin A lay on Patient A's abdomen, Dr. Fletcher put a laparotomy sponge or piece of gauze in Twin A's mouth. There was no medical justification for any of these three procedures. These procedures delayed the time during which normal post-natal care could be provided to Twin A.

Twin A had Apgar scores of 9 and 9 and a heart rate of 80 beat per minutes, signs of a very healthy baby. Dr. Portner told the nurses in the delivery room that Twin A was not to be resuscitated[4] and that no procedures or neonatal management efforts be initiated to keep Twin A alive. Twin A did not, in fact, need resuscitation or any unusual procedures. Dr. Portner prevented the nurses from providing normal care. Nursing personnel objected to Dr. Portner's orders and wanted to take Twin A to the neonatal intensive care unit (NICU). One nurse ultimately ignored Dr. Portner's orders and took

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[4]A DNR (Do Not Resuscitate) Order is moot when the baby is healthy.

Twin A to the NICU. Dr. Portner came into the NICU and berated the nurse who took Twin A to the NICU. Twin A survived.

These obstetrical events represent mismanagement of the prenatal care and delivery of Patient A. Specifically, Dr. Portner ordered a cephalocentesis which was not justified by any medical reason. In addition, he delayed proper care and usual and customary support measures for Twin A by delivering Twin A's head without the rest of the body for several minutes; by placing and keeping Twin A on Patient A's abdomen for an inappropriately long period of time after Twin A's delivery; by placing, or allowing to be placed, a laparotomy sponge or cloth in Twin A's mouth after delivery; by failing to plan, provide and undertake appropriate neonatal management or life support measures for Twin A; and by ordering that nursing personnel in the delivery room not undertake any neonatal management or life support efforts of Twin A.

DISCUSSION

The Board adopts the Administrative Law Judge's Discussion of this case as set forth in the Administrative Law Judge's September 23, 1998 Proposed Decision and in the September 13, 1999 Proposed Decision on Remand except for certain statements in the Discussion section of the September 23, 1998 Proposed Decision.[5]

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[5]The Board does not adopt the following statements in the Discussion section of the Administrative Law Judge's September 23, 1998 Proposed Decision:

(1) Page 19, second paragraph "[Dr. Portner], planned to induce the death of Twin A," and page 21, third paragraph, second sentence - "The Respondent wanted to induce fetal death; that was his plan from the beginning." The Board adopts these paragraphs insofar as they find that Dr. Portner neither informed Patient A nor documented in the medical record what his plan was with respect to the hydrocephalic twin, and that the reason for the cephalocentesis at the time it was performed was medically inexplicable. Although the Board has adopted many of the findings which relate to Dr. Portner's intentions with regard to the hydrocephalic twin (see, e.g., findings

The Administrative Law Judge commented that these serious and otherwise inexplicable violations of the standard of care are best explained by an intent to cause the demise of the infant. This comment is not unwarranted, given the facts of this case. The Administrative Prosecutor, however, characterized Dr. Portner's conduct as a blind, "wrongheaded" persistence in viewing this fetus as non-viable, and continuing on a course of action that had been planned based upon the presumption of a non-viable fetus, despite all of the evidence to the contrary. The Board believes that this "wrongheaded" persistence in refusing to acknowledge the plain medical facts apparent right before his eyes is the cause of the multiple violations of the standard of care and the egregious unprofessional conduct. The Board thus agrees with the Administrative Prosecutor's portrayal of this part of the case.

The findings of fact in this case reveal a series of violations of the standard of care with respect to the care provided to Patient A and her hydrocephalic twin baby. These

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numbers 20, 42, 48, 53 and 54), the Board has not adopted the finding that Dr. Portner's premeditated intent was to cause the demise of the hydrocephalic twin irrespective of any later medical developments. (See Administrative Law Judge's September 23, 1998 Proposed Decision, finding of fact number 19, rejected by the Board.)

(2) Page 23, first paragraph, last sentence - "[T]he evidence overwhelmingly supports the inference that the Respondent's intent was to kill the baby, the only reason for allowing it to lay on the mother's abdomen for so long was to assist in that process," and page 24, last paragraph, second sentence, second clause -- his intent was not just to follow the parent's request of non-resuscitation, but to induce the fetal death of Twin A, whatever her state of viability." The Board does not adopt those statements.

In all other respects, however, the Board agrees with the Discussions of the Administrative Law Judge in both Proposed Decisions regarding the merits of the case. As the Board pointed out in its Interim (Remand) Order, however, Dr. Portner was not charged with the intent to cause the demise of this viable infant.

violations include performing cephalocentesis on the hydrocephalic twin without medical justification after the healthy twin baby had been delivered by Caesarian. They include delivering the head and sholders of Twin A and delaying further action for several minutes, placing the hydrocephalic twin on the mother's abdomen and ordering the nurses not to do anything for this baby, and permitting the placement of a laparotomy sponge (or gauze cloth) in the baby's mouth without medical justification. The violations include failure to assure that there was a pediatrician or neonatologist available at delivery, and reprimanding a nurse for calling for one after it was apparent that this hydrocephalic baby was viable.

This is clearly not a case, as Dr. Portner contends, in which he simply followed his patient's wishes that no heroic measures be undertaken. No heroic measures were required for this baby; it was ordinary, standard care which Dr. Portner did not provide, and which he attempted to keep others from providing. Nor is it a case in which he performed the life-threatening procedure of cephalocentesis in order to aid the mother in her delivery or to assure the viable delivery of the non-hydrocephalic twin. There was no need to aid the mother in delivery, as this was a Caesarian section; and there was no need to assure the viable delivery of the non-hydrocephalic twin, as that other baby had already been born. The actions taken by Dr. Portner with respect to this viable hydrocephalic infant were completely inappropriate and not justified by any of the reasons he has given for them.

With respect to the sanction, however, the Board believes that the recommended sanction of revocation is too severe. These were egregious and serious violations of the standard of care and of professional standards of conduct. This conduct was apparently caused by a failure to pay full attention to his own consultant's advice, a failure to adequately inform his patient, a failure to pay attention to the plain medical facts when they

were contrary to his expectations, and a willingness to usurp normal medical protocols in order to effectuate his preconceived plan. While the Board will not revoke his license, the Board has no doubt that remedial educational action is warranted. In addition, the Board concludes that a sanction of sufficient severity to deter the Dr. Portner and others from engaging in similar reprehensible conduct is called for. The Board concludes that a suspension of six months will have sufficient deterrent effect on Dr. Portner and on others, and that Dr. Portner may thereafter be permitted to practice again, provided that the remedial educational requirements set out below are also successfully fulfilled.

NO OTHER TEXT ON THIS PAGE.

CONCLUSIONS OF LAW

Based on the foregoing facts, the Board adopts the Conclusions of Law as set forth in the Administrative Law Judge's September 23, 1998 Proposed Decision and September 13, 1999 Proposed Decision on Remand with the exception noted in footnote number 6.[6]

Dr. Portner's conduct was unprofessional because of his blatant violations of the standard of care and reasonable professional protocols, e.g., ordering the nurses to get away from, and not care for, a viable infant.

With respect to Patient B (Case No. 97-0512), the Board **DISMISSES** the charges effective the date of the Board's Interim Order of December 30, 1998.

With Respect to Patient A (Case No. 96-0480), the Board concludes that Dr. Portner violated § 14-404(a)(22) by failing to provide appropriate care and also violated § 14-404(a)(3) by committing unprofessional conduct in the practice of medicine.

ORDER

Based on the foregoing, it is this 31st day of May, 2000, by a majority of the full authorized membership of the Board,

ORDERED that the license of Barry Portner, M.D., License Number D09675, be **SUSPENDED**, effective ten (10) days from the date of this Final Order, and that the suspension continue for a minimum of six (6) months from the effective date of suspension **AND** until all of the following three (3) conditions are met:

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[6]The Board rejects the Administrative Law Judge's conclusion of law that Dr. Portner intentionally attempt[ed] the fetal demise of a viable infant during delivery. Proposed Decision of September 23, 1998 at p. 29 and Proposed Decision on Remand at p. 20 (Conclusion (1)(a)).

(1) Dr. Portner successfully completes, at his own expense, a course in the management of high risk pregnancy. This course must be approved in advance by the Board. The Board will approve a course only if it deems the curriculum and the duration of the course adequate to fulfill the need.

(2) Dr. Portner completes a course in medical ethics at his expense. This course also must be approved in advance by the Board, under the conditions stated in (1) above.

(3) Dr. Portner must appear before the Board's Case Resolution Conference subsequent to the six-month suspension period and explain how the completion of the requirements of (1) and (2) above would affect his actions should a similar case be presented to him in the future.

ORDERED that Dr. Portner shall be responsible for all costs necessary to comply with this Final and Order; and be it further

ORDERED that if Dr. Portner fails to comply with the terms of this Final Order, the Board, after notice and hearing and a determination of violation, may impose any other disciplinary sanctions it deems appropriate, said violation of this Final Order being proved by a preponderance of evidence, and be it further

ORDERED that this is a Final Order of the Maryland State Board of Physician Quality Assurance, and, as such, is a **PUBLIC DOCUMENT** pursuant to the Maryland State Gov't Code Ann., §§ 10-611 et seq.

5/30/02
Date

Sidney B. Seidman, M.D.
Chairman
Maryland State Board of Physician Quality Assurance

NOTICE OF RIGHT TO APPEAL

Pursuant to Maryland Health Occupations Code Ann., § 14-408, Respondent has the right to take a direct judicial appeal. Any appeal shall be made as provided for judicial review of a final decision in the Administrative Procedure Act, State Government Article and Title 7, Chapter 200 of the Maryland Rules of Procedure.

a:1Portner.FO
2Orders:5/31/00

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
4201 Patterson Avenue • Baltimore, Maryland 21215-2299
Parris N. Glendening, Governor - Georges C. Benjamin, M.D., Secretary

June 7, 2000

VIA FACSIMILE AND MAIL

Robert B. Schulman, Esquire
Schulman, Treem, Kaminkow & Gilden, P.A.
Suite 1800
The World Trade Center
401 East Pratt Street
Baltimore, Maryland 21202

Re: In the matter of Barry Portner, M.D.
Letter of June 5, and June 7, 2000

Dear Mr. Schulman:

The Board of Physician Quality Assurance (the "Board") received your June 5, 2000 letter requesting that the effective date of the suspension of Dr. Portner's medical license be delayed until June 30, 2000. The Weekly Review Panel ("WRP") of the Board has considered your request and decided to grant your request that the effective date of Dr. Portner's suspension be extended until June 30, 2000.

On June 7, 2000, the Board received your second request for further delay of the effective date of the suspension period, which is moot in light of the determination of the WRP.

Sincerely,

Barbara K. Vona
Chief of Compliance

c: Robert J. Gilbert, Esquire