IN THE MATTER OF	*	**BEFORE THE**
JEAN M. EISENBREY, M.D.	*	**BOARD OF PHYSICIAN**
Respondent	*	**QUALITY ASSURANCE**
License Number D16180	*	**Case Number 2001-0447**

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CONSENT ORDER

PROCEDURAL BACKGROUND

On February 5, 2003, the State Board of Physician Quality Assurance (the "Board") charged Jean M. Eisenbrey, M.D. (the "Respondent") (D.O.B. 08/30/47), License Number D16180, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") § 14-101 et seq. (1994).

Specifically, the Board charged the Respondent with violating the following provision of the Act under H.O. § 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.

On Wednesday, May 21, 2003, a Case Resolution Conference was convened regarding this matter. Based on negotiations which occurred as a result of this Case Resolution Conference, the Respondent agreed to enter into this Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board finds the following:

1. 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 in 1974 under License Number D16180.

2. The Respondent specializes in the practice of pediatric medicine, and maintains offices at the following locations: 9131 Piscataway Road, Suite 340, Clinton, Maryland 20735; and 2955 Crain Highway, Waldorf Medical Park, Waldorf, Maryland 20601.

3. On or about April 14, 2000, the parent of Patient A, a newborn child, filed a claim against the Respondent before the Maryland Health Claims Arbitration Office, alleging that the Respondent was negligent and violated applicable standards of care in her assessment and treatment of Patient A.[1] The claim alleged that during the seven-week period in which the Respondent provided medical care to Patient A, she failed to appropriately evaluate Patient A's condition, consisting of persistent vomiting, weight loss, progressive dehydration and electrolyte imbalance, leading to seizures and coma, which resulted in permanent brain damage. After being hospitalized, Patient A was diagnosed with having a pyloric stenosis.

4. Based on the above claim, the Board initiated an investigation of this matter.

5. Pursuant to its investigation, the Board, on or about May 29, 2001, referred

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[1]To ensure confidentiality, Patient A's name is not set forth in this document. The Respondent is aware of Patient A's identity, however.

this matter to the Peer Review Management Committee (the "PRMC") of the Medical and Chirurgical Faculty of Maryland ("Med-Chi") for investigation. The PRMC then referred this investigation to the Med-Chi Peer Review Committee ("PRC").

6. On or about May 16, 2002, the Med-Chi PRC submitted a written report of its findings to the Board. In its report, the PRC concluded that the Respondent failed to meet appropriate standards of care in her assessment and treatment of Patient A.

PATIENT - SPECIFIC FINDINGS

7. Patient A, a female child, was born on February 26, 1997 at Physician's Memorial Hospital ("Physician's Memorial"), located in LaPlata, Maryland, to a woman with gestational diabetes. Patient A's birth weight was 10 lbs. 6 oz. Patient A's birth was approximately 2 ½ weeks premature.

8. Patient A was delivered by cesarean section for macrosomia, and immediately developed apnea (breathing difficulties), hypocalcemia, and hypoglycemia.

9. Because of these conditions, Patient A was transferred to Georgetown University Hospital ("Georgetown") on February 26, 1997, where she was evaluated for possible sepsis neonatorum, and was treated for hypoglycemia and hypocalcemia. During her admission, Patient A's medical conditions resolved, and she was discharged on March 5, 1997.

10. On or about March 7, 1997, Patient A was first seen by the Respondent at her office for a follow-up visit after her discharge from Georgetown. Patient A was 9 days old. Patient A was measured as weighing 10 lbs. 5 oz., but length and head circumference were not documented. The Respondent did not record a full examination of Patient A in

her record entry for this date. The Respondent noted that Patient A was sleeping, her ears and throat were "clear," and her skin had "mild jaundice." The Respondent's record also indicated that Patient A was taking 4-to-4 ½ oz. of expressed breast milk per feeding, was having normal loose stools, was "doing well," and had "no problems." The Respondent ordered that Patient A return for a follow-up examination in two weeks.

11. On or about March 21, 1997, Patient A returned for a "well baby" visit, at which time the Respondent recorded more complete historical data and performed a more complete physical examination. The Respondent reviewed particular details of Patient A's hospitalization, obtained a feeding and sleep history and a record of the child's crying. Patient A was recorded as taking 5-to-7 oz. of breast milk per feeding, although the frequency of the feedings was not recorded.

12. The Respondent's examination of Patient A documented that Patient A weighed 11 lbs. 4 oz. (a 15 oz. weight gain in the 2 week interval since her March 7, 1997 examination), and that her weight was measured as being in the 95th percentile. The Respondent recorded a checklist examination as being entirely normal, although specifics were not noted. The Respondent did not document or record that she provided any anticipatory guidance. Under the assessment portion of the examination form, the Respondent recorded Patient A as "well baby." The Respondent recorded that she administered a second Hepatitis vaccine and performed a PKU test. A return well baby visit was scheduled.

13. On or about April 15, 1997, Patient A's mother reportedly contacted the Respondent by telephone during the evening hours, and advised her that Patient A had

begun vomiting. The Respondent reportedly told Patient A's mother that a 24-to-48 hour virus was "going around," and that Patient A should be given a soy-based formula and Pedialyte. Patient A's mother reportedly advised the Respondent that no one in the family home was ill other than Patient A. The fact and the content of this phone call are disputed, but if it occurred as alleged, the Respondent did not record this telephone conversation in Patient A's medical records.

14. As of April 17, 1997, Patient A continued to experience vomiting. On this date, Patient A's mother again reportedly contacted the Respondent by telephone and advised her of Patient A's condition. The Respondent reportedly indicated to Patient A's mother that Patient A had perhaps suffered a "relapse," and instructed her to bring Patient A to her office if her condition did not improve. The fact and the content of this phone call are disputed, but if it occurred as alleged, the Respondent did not record this telephone conversation in Patient A's medical records.

15. On or about April 18, 1997, Patient A was still vomiting, and her mother then made an appointment and brought Patient A to see the Respondent at her office that day.

16. The Respondent's office note for April 18, 1997 is designated as a "SV" (sick visit); and that Patient A's symptoms were as follows: "vomiting x 3d. no diarrhea. voiding well." The Respondent did not document the frequency of Patient A's stooling or urination. The Respondent documented that Patient A was taking an indeterminate amount of expressed breast milk.

17. The Respondent recorded that on this visit, Patient A weighed 12 lbs. 2 oz., and had a temperature of 96.8 degrees. The Respondent did not record any other vital

signs. The only additional information recorded were of Patient A's general appearance ("alert and active"); her ears ("TM's [tympanic membranes] clear"); and her throat and lungs (both "clear").

18. The Respondent recorded her assessment as "? gastroenteritis"; and that her plan was to "continue Pedialyte today and tomorrow." The Respondent noted that she would reassess Patient A "if worse."

19. On or about April 24, 1997, Patient A was examined by the Respondent pursuant to a 2-month well-baby examination. The Respondent recorded some historical information, including "less spitting than before. Some eye discharge." The Respondent recorded that Patient A was now being fed Enfamil, about 5 oz. per feeding. The Respondent recorded Patient A's weight on this visit as 11 lbs. 12 oz. (6 oz. less than her prior visit, April 18, 1997); temperature 97.8 degrees; height at 23 ½ inches; and head circumference of 16 inches. A checklist examination was recorded as normal although the Respondent recorded no assessment for growth/nutrition, or neurological assessment. The Respondent recorded her assessment as "well visit, improved spitting." The Respondent administered DPT, polio, and Hib vaccines, and ordered that Patient A be brought back for examination in 2 months.

20. On April 29, 1997, Patient A's mother brought Patient A to see the Respondent at her office. The Respondent recorded that "infant spitting up-not every feeding. Not projectile by description." The Respondent recorded that Patient A was "stooling and voiding," but did not record the frequency. The Respondent did not weigh Patient A on this visit (under the weight portion of the chart, the Respondent noted that

Patient A weighed "11-12 on 4/24"). The Respondent's assessment was "suspect GI reflux." The Respondent prescribed Reglan and Cisapride to be given "before feeds," and that "if not better controlled, must do UGI."

21. On or about April 29, 1997, Patient A's mother reportedly determined that Patient A was developing a cold, and treated her with Pediacare (an over-the-counter medicine).

22. On or about May 1, 1997, Patient A's mother reportedly noted that Patient A's vomiting was somewhat better, although Patient A was not her "usual self," in that she was "fussy" and still had a cough and cold. On this date, Patient A's mother reportedly telephoned the Respondent's office regarding her concern about Patient A's reaction to the reflux medication. The Respondent's nurse reportedly advised that she thought that Patient A's cold was aggravating the reflux problem, and that Patient A should continue to receive the reflux medication. Patient A's mother then continued to give Patient A Pediacare for her cold and cough. The fact and content of this phone call are disputed, but if it occurred as alleged, there is no record of this telephone conversation in the Respondent's medical records or in the office phone log book.

23. On or about Saturday May 3, 1997, Patient A reportedly was continuing to vomit, and her cough had worsened. Patient A's mother then reportedly telephoned the Respondent's answering service and then spoke to the Respondent, who recommended that Patient A be given Triaminic, a different over-the-counter medication, to treat her cough. The fact and content of this phone call are disputed, but if they occurred as alleged, the Respondent did not document this telephone conversation in her medical

records. No other calls were made to the Respondent.

24. Patient A continued to be ill over the weekend of May 3-4, 1997. During the early morning hours of May 5, 1997, Patient A's mother observed that Patient A had awakened with a "strange cry," her head "was shaking back and forth," and she had a "strange sound" in her chest.

25. Patient A's parents then transported Patient A to the Emergency Department at Physician's Memorial, where Patient A experienced periods of apnea, was exhibiting tonic seizure activity, and was unresponsive. Patient A's weight was measured as being 11 lbs. Patient A was diagnosed with severe dehydration and seizure disorder. Patient A was then transported to Children's National Medical Center ("Children's Hospital"), located in Washington, D.C.

26. Patient A was admitted to Children's Hospital with severe dehydration, metabolic alkalosis and seizure disorder. Patient A was diagnosed with cortical atrophy and pyloric stenosis. Patient A was then placed on antiseizure medications. Her seizures continued to be persistent, however, requiring that she be placed in a drug-induced coma. Patient A remained in status epilepticus for over 2 days.

27. Patient A continued to remain in the Pediatric Intensive Care Unit until May 13, 1997. On May 19, 1997, Patient A was sufficiently stabilized, at which point she underwent a pyloromyotomy to repair a pyloric stenosis.

28. The reviewers concluded that Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care with respect to her evaluation and treatment of Patient A, a violation of H.O. § 14-404 (a)(22). Specifically, the

reviewers concluded that Dr. Eisenbrey deviated from applicable standards, as set forth below:.

29. During the course of her evaluation and treatment of Patient A, the Respondent failed to adequately assess and/or recognize Patient A's persistent symptoms, which consisted of weight loss, and vomiting/regurgitation.

30. Although Patient A was measured as having lost weight, and was experiencing persistent vomiting or regurgitating, the Respondent failed to perform or document performing a complete physical examination, including an abdominal examination on the visit of April 29, (although she had done an abdominal examination on April 24, which was normal). No laboratory or radiologic testing was done to evaluate the etiology of Patient A's condition.

31. The Respondent failed to document sufficient historical details with respect to Patient A's developing condition; and failed to measure and/or record measuring important patient vital signs, such as Patient A's weight, on all visits, particularly in view of the fact that the Respondent was treating a potentially dehydrating condition.

32. The Respondent failed to diagnose and treat Patient A's pyloric stenosis, or order tests to evaluate Patient A's condition.

33. The Respondent failed to recognize the significance of Patient A's condition, including weight loss and vomiting/regurgitation, and failed to conduct complete physical examinations on with respect to Patient A's developing condition.

34. *Examples of the above deficiencies include but are not limited to the* following:

a. the Respondent failed to perform and/or failed to document a complete examination of Patient A during Patient A's initial visit, dated March 7, 1997;

b. the Respondent failed to provide and/or failed to document providing anticipatory guidance to Patient A's mother or alternate caregiver during the course of patient visits, e.g., March 7, 1997, March 21, 1997, April 24, 1997;

c. after Patient A's well-baby visit of March 21, 1997 and before her sick visit on April 18, 1997, it is alleged Patient A's mother contacted the Respondent by telephone regarding the progression of Patient A's condition. If true, The Respondent failed to record in her medical record the substance of these telephone contacts;

d. the Respondent failed to perform or document performing a complete evaluation of Patient A on Patient A's April 18, 1997 visit. On this visit, Patient A's mother reported that Patient A had been vomiting for 3 days and had a temperature of 96.8 degrees. The Respondent failed to perform or document findings of an abdominal examination or other testing to investigate the source of Patient A's symptoms;

e. the Respondent failed to appropriately assess Patient A during Patient A's well-baby examination of April 24, 1997. At this point, Patient A had lost 6 oz. The Respondent failed to appropriately evaluate and/or address Patient A's weight loss. The Respondent failed to document a detailed historical account of Patient A's condition, particularly with respect to the frequency of Patient A's vomiting/regurgitation, other than "less spitting now than before." On this visit, the Respondent ordered that Patient A be seen in 2 months, an inappropriate interval in view of Patient A's weight loss and other symptoms. The Respondent did not document in Patient A's record on this date that she recognized Patient A's weight loss, (although the weight loss is documented, as is a negative abdominal examination), her concern about the ramifications of this condition, or that the child should be evaluated more carefully or with greater frequency should her condition not resolve;

f. the Respondent failed to appropriately assess Patient A during Patient A's sick visit of April 29, 1997. At this point, Patient A had been brought in for an evaluation because she had continued to

"spit up." The Respondent failed to appropriately assess Patient A on this visit, who had lost weight since her prior visit. The Respondent failed to obtain a detailed historical account of Patient A's condition, including but not limited to the frequency of Patient A's vomiting, the volume of spitting, the color of the vomit, or the frequency of stooling and voiding. The respondent documented that the vomiting was not projectile. The Respondent failed to obtain Patient A's weight, notwithstanding her prior weight loss and continued regurgitation. The Respondent failed to perform an abdominal examination or address Patient A's weight loss during this visit;

g. on this visit, the Respondent inappropriately prescribed two gastroesophageal reflux medications which were to be given simultaneously;

h. the Respondent failed to appropriately assess and monitor Patient A's continuing symptoms after her April 29, 1997 office visit. It is alleged, but disputed, that on May 1, 1997, Patient A's mother contacted the Respondent's office, and on May 3, 1997, spoke directly with the Respondent regarding Patient A's continuing vomiting and other symptoms. If true, the Respondent failed to document these conversations in Patient A's medical record. At this point the Respondent failed to evaluate Patient A in a timely matter, or alternatively, failed to maintain continuing telephone contact with Patient A's mother to monitor Patient A's developing condition;

I. The Respondent failed to diagnose or appropriately assess Patient A's weight loss and conditions which may have produced dehydration.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that 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, in violation of Md. Health Occ. Code Ann. § 14-404(a)(22).

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is this 25th day of June, 2003, by a majority of the full and authorized membership of the Board considering this case:

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

ORDERED that said **SUSPENSION** shall be immediately **STAYED**; and be it further

ORDERED that the Respondent shall be placed on **PROBATION** for a **PERIOD OF TWO (2) YEARS** from the effective date of this Consent Order, that date being the date the Board executes this Consent Order, subject to the following terms and conditions:

1. Within twelve (12) months of the effective date of this Consent Order, the Respondent's practice shall be subject to peer review by an appropriate peer review society, or a chart review by a Board designee, to be determined at the discretion of the Board. This chart review may focus on, but shall not be limited to, cases involving infants with gastrointestinal disorders, and general pediatric conditions/issues. After a random chart review, the Board may recommend a peer review.

2. The Respondent shall enroll in and successfully complete Board-approved continuing medical education courses in the following subject area: management of gastrointestinal disorders in infants. The Respondent shall submit the course descriptions AND/OR syllabus to the Board prior to enrolling in the courses. The Board reserves the right to reject the course(s) submitted for fulfillment of this condition, and may request additional information regarding the course(s). The Respondent shall enroll in the course(s) within six (6) months (provided course enrollment is available within this time frame) of the effective date of this Consent Order, and shall successfully complete the course(s) within **twelve (12) months** of the effective date of this Consent Order. The Respondent shall submit written verification of course completion within fifteen (15) business days after completing the course.

3. The Respondent shall enroll in a Board-approved medical record-keeping course, and shall complete the course within **twelve (12)**

months of the effective date of this Order. The Respondent shall obtain approval of the course from the Board prior to enrolling in the course.

4. The above courses shall be in addition to the Respondent's *Continuing Medical Education requirements mandated for* continuing licensure;

5. Within forty-five (45) days of the effective date of this Consent Order, the Respondent shall obtain a Board-approved physician supervisor (hereinafter the "physician-supervisor"), who is Board-certified in pediatrics to supervise her practice. The Respondent shall obtain prior approval from the Board before entering into this supervisory arrangement. As part of the approval process, the Respondent shall provide the Board with the curriculum vitae and any other information requested by the Board regarding the qualifications of the practitioner who is submitted for approval. The supervisory arrangement shall be subject to the following:

a. The physician-supervisor shall have no formal professional alliance, such as a partnership or corporation, and no financial relationship with the Respondent;

b. The physician-supervisor shall notify the Board in writing of his/her acceptance of the supervisory role with the Respondent;

c. The Respondent shall provide to the physician-supervisor a copy of the charging document, Consent Order, and any other documents that the Board deems relevant;

d. The Respondent shall meet with the physician-supervisor **bi-weekly**, i.e. **twice per month**, during the **first twelve (12) months** of the probationary period. The physician-supervisor shall randomly select pediatric records of the Respondent's patients and review and discuss with the Respondent her treatment plan, medical decisionmaking, and compliance with appropriate standards of care. The physician-supervisor shall review the patient records and discuss his/her assessment of the Respondent's practice performance with the Respondent;

e. At the conclusion of the first **twelve (12) months** of supervision, the physician-supervisor shall, in his/her report, advise the Board as to whether the Respondent should continue receiving supervision on a biweekly basis, or whether the Respondent may receive supervision on a **monthly** basis. The Board reserves the right to require the physician-supervisor to provide

further information for the basis of his/her recommendation. The Board retains sole decision-making authority over the frequency of the Respondent's practice supervision.

f. The physician-supervisor shall submit written reports to the Board on a quarterly basis regarding his/her assessment of the Respondent's compliance with appropriate standards of care and her medical judgment/decision making;

g. The Respondent shall have sole responsibility for ensuring that the physician-supervisor submits the required quarterly reports to the Board in a timely manner;

h. The Respondent may petition the Board for termination of practice supervision at the end of one (1) year.

6. The Respondent shall document in her medical records, or in a telephone call log book, all telephone calls received from patient/family members of patients/responsible person(s) regarding patient medical conditions.

7. The Respondent shall practice according to the Maryland Medical Practice Act and in accordance with all applicable laws. This provision shall apply to all acts/matters occurring after the effective date of this Consent Order.

AND BE IT FURTHER ORDERED that if the Respondent violates any of the terms or conditions of this Consent Order, after notice and a hearing, and a determination of the violation, the Board may impose any other disciplinary sanctions it deems appropriate, said violation of probation being proved by a preponderance of the evidence; and be it further

ORDERED that after the conclusion of the entire **TWO (2) YEAR** period of **PROBATION**, the Respondent may file a written petition for termination of his probationary status without further conditions or restrictions, but only if the Respondent has satisfactorily complied with all conditions of this Consent Order, including all terms and conditions of probation, including the expiration of the **TWO (2) YEAR** period of probation, and if there

are no pending complaints regarding the Respondent before the Board; and be it further

ORDERED that the Respondent shall not petition the Board for early termination of her probationary period or the terms of this Consent Order, exclusive of probationary condition 5(h) above; and be it further

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

ORDERED that this Consent Order is considered a **PUBLIC DOCUMENT** pursuant to Md. State Gov't. Code Ann. § 10-611 et seq. (1995).

6/25/03
Date

C. Irving Pinder, Jr.
Executive Director
Board of Physician Quality Assurance

CONSENT

I, Jean M. Eisenbrey, M.D., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I admit to the Findings of Facts and Conclusions of Law, and I agree and accept to be bound by the foregoing Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

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 as provided by law. I acknowledge the legal

authority and the jurisdiction of the Board to initiate these proceedings and to issue and enforce the Consent Order. I also affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

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

6-4-03
Date

Jean M Eisenbrey, MD
Jean M. Eisenbrey, M.D.
Respondent

STATE OF MARYLAND
CITY/COUNTY OF:

I HEREBY CERTIFY that on this 4th day of June, 2003, before me, a Notary Public of the State and County aforesaid, personally appeared Jean M. Eisenbrey, M.D., 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.

Carol L Ondrejka
Notary Public

My commission expires: 12/1/05

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