IN THE MATTER OF	*	BEFORE THE
SARKIS G. AGHAZARIAN, M.D.	*	STATE BOARD
Respondent	*	OF PHYSICIANS
License Number: D28245	*	Case Number: 2000-0904

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

CONSENT ORDER

PROCEDURAL BACKGROUND

On March 3, 2003, the State Board of Physicians[1] (the "Board") charged Sarkis G. Aghazarian, M.D,. (the "Respondent"), DOB: 11/16/54, with violating the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") § 14—101 *et seq.*

The pertinent provision of the Act under H.O. § 14-404(a) provides as follows:

> 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:
>
> (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 April 16, 2003, a conference with regard to this matter was held before the Case Resolution Conference (the "CRC"). As a result of negotiations entered into after the CRC, the Respondent agreed to enter into this Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law and Order.

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[1] Effective July 1, 2003, in accordance with Senate Bill 500, the former Board of Physician Quality Assurance was reconfigured and renamed the State Board of Physicians.

FINDINGS OF FACT

1. At all times relevant hereto, the Respondent, who is board-certified in general surgery, was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed in Maryland on August 20, 1982. The Respondent also holds an active license to practice medicine in California.

2. At all times relevant to the events herein, the Respondent held privileges at Union Memorial Hospital in Baltimore, Maryland.

3. In or around July 2000, the Board initiated an investigation of the Respondent's care and treatment of a patient (hereinafter "Patient A"[2]) based on the receipt of a complaint filed by the patient's spouse with the Health Claims Arbitration Office alleging that the Respondent provided substandard care to Patient A. Specifically, the Respondent was alleged, *inter alia,* to have failed to adequately diagnose and treat a serious infection that subsequently resulted in Patient A's cardiac arrest and death.

4. As part of its investigation, the Board referred the matter to the Peer Review Management Committee of the Medical and Chirurgical Faculty of Maryland ("Med-Chi") for a review of the incident.

5. The Peer Review Committee concluded that the Respondent violated appropriate standards for the delivery of quality medical care in his assessment and treatment of Patient A.

[2] To ensure confidentiality, the name of the patient is not used in this Consent Order.

Patient-Specific Findings of Fact

6. Patient A, an eighty-six (86) year old male, initially presented to the Emergency Department on July 25, 1999 complaining of rectal bleeding.

7. On July 26, 1999, a physician other than the Respondent conducted an acute gastrointestinal blood loss imaging procedure on Patient A. The results of the imaging procedure indicated that the source of the bleed could not be determined.

8. On July 27, 1999, the Respondent conducted an esophagogastroduodenoscopy ("EGD") and a colonoscopy to determine the source of the bleeding. The procedures indicated non-localized bleeding from diverticulosis coli with fresh clots of blood throughout the entire colon. The Respondent recommended that Patient A undergo a subtotal colectomy with ileostomy.

9 On July 28, 1999, the Respondent conducted a subtotal colectomy with ileostomy on Patient A. Patient A tolerated the procedure well.

10. On August 11, 1999, Patient A returned to the Respondent for a post-operative visit. The Respondent noted that Patient A was doing well and that he (the Respondent) planned to take down the ileostomy in one (1) month.

11. On September 1, 1999, Patient A returned to the Respondent with complaints of a three (3) or four (4) day history of nausea, dyshagia and persistent weight loss. Patient A did not complain of fever or

chills. The Respondent noted: "["Patient A] has questionable gastric outlet obstruction vs. gastroparesis and air fluid level." The Respondent noted that Patient A was to undergo an EGD the next morning for the purpose of ruling our esophageal cancer, gastric cancer or gastroparesis.

12. During the September 1, 1999 visit, the Respondent ordered CBC and Chemistry Profile 1 studies.

13. Blood samples were collected from Patient A on September 1, 1999 at 10:51 a.m. The results of the chemistry profile revealed that Patient A's potassium level was 8.4 (reference range = 3.6 – 5.0) and was noted on the lab report to be "CH" or critically high.

14. The results of the September 1, 1999 chemistry profile also revealed that Patient A's blood urea nitrogen ("BUN") level was 88 (reference range = 9 – 20), his creatinine level was 6.0 (reference range = 0.8 – 1.5) and anion gap was 17 (reference range = 5 – 15). All of these values were designated as "H" or high on the lab report.

15. On September 2, the Respondent conducted the EGD on Patient A as he had planned. The results of the EGD were unremarkable and no obstruction or blockage was found.

16. The Respondent failed to review the chemistry profile prior to conducting the September 2, 1999 procedure.

17. On September 6, 1999, Patient A was transported to Johns Hopkins Hospital in full cardiac arrest. Resuscitation efforts failed and Patient A expired at 8:45 a.m.

18. Patient A's subsequent autopsy revealed BUN and creatinine levels that were consistent with those of the September 1, 1999 chemistry profile. The autopsy report concluded that Patient A died "in a course of severe renal failure developing most probably due to acute pyelonephritis."

19. The peer reviewers concluded that the Respondent violated the standard of care for the delivery of quality medical services to Patient A because he failed to review Patient A's September 1, 1999 chemistry profile and failed to act on the results.

CONCLUSION OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's actions constitute a violation of the appropriate standard of care for the delivery of quality medical services, in violation of H.O. § 14-404(a)(22).

ORDER

Based on foregoing Findings of Fact and Conclusions of Law, it is this 23 day of July, 2003:

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

ORDERED that this Consent Order is considered a public document, pursuant to Md. State Gov't Code Ann. § 10-611 *et seq.*

July 23, 2003
Date

Margaret T. Anzalone
Margaret T. Anzalone
Deputy Director
State Board of Physicians

CONSENT

I, Sarkis G. Aghazarian, M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering this Consent Order.

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 the law. I acknowledge that a formal evidentiary hearing could result in a decision that the Findings of Fact and Conclusion of Law were proven. Therefore, while not admitting to the Findings of Fact and Conclusions of Law, I do voluntarily enter into and submit to this Consent Order. 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 followed after any such hearing.

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

7/14/03
Date

Sarkis G. Aghazarian, M.D.
Respondent

STATE OF MARYLAND
CITY/COUNTY OF Anne Arundel

I HEREBY CERTIFY that on this 18th day of July, 2003, before me, a Notary Public of the foregoing State and City/County personally appeared Sarkis G. Aghazarian, M.D., License Number D28245, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

[signature]
Notary Public
My Commission expires 6/1/05