IN THE MATTER OF	*	**BEFORE THE**
IRIS E. DOMINY, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D30890	*	**Case Number: 2013-0722**

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CONSENT ORDER

PROCEDURAL BACKGROUND

On September 26, 2013, the Maryland State Board of Physicians (the "Board") charged **IRIS E. DOMINY, M.D.** (the "Respondent"), License Number D30890, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.*; and the Md. Regs. Code ("COMAR") tit. 10, § 32.12 *et seq.*

The Board charged the Respondent with violating the following provisions of the Act under H.O. § 14-404(a):

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

(18) Practices medicine with an unauthorized person or aids an unauthorized person in the practice of medicine; [and/or]

(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[.]

The Board also charged the Respondent with violating the following COMAR provisions:

10.32.12.04 Scope of Delegation.

E. A physician may not delegate to an assistant acts which include but are not limited to:

(1) Conducting physical examinations;

(2) Administering any form of anesthetic agent or agent of conscious sedation other than topical anesthetics or small amounts of local anesthetics;

(3) Initiating independently any form of treatment, exclusive of cardiopulmonary resuscitation;

(4) Dispensing medications;

(5) Giving medical advice without the consult of a physician[.]

10.32.12.05 Prohibited Conduct.

B. A delegating physician, through either act or omission, facilitation, or otherwise enabling or forcing an assistant to practice beyond the scope of this chapter, may be subject to discipline for grounds within Health Occupations Article, § 14-404(a), Annotated Code of Maryland, including, but not limited to, practicing medicine with an unauthorized person or aiding an unauthorized person in the practice of medicine.

On October 2, 2013, a Case Resolution Conference was convened in this matter. Based on negotiations occurring as a result of this Case Resolution Conference, the Respondent agreed to enter into this Consent Order, which consists of Procedural Background, Findings of Fact, Conclusions of Law, Order, Consent and Notary.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

BACKGROUND FINDINGS

Licensing/Credentialing/Employment information

1. The Respondent was initially licensed to practice medicine in Maryland on June 12, 1984, under License Number D30890.

2. The Respondent's license to practice medicine remained active through May 29, 2013, when the Board issued an Order for Summary Suspension (the "Order")

in which it summarily suspended her license to practice medicine in Maryland. The Board based its Order on the Respondent's actions while practicing at Associates in OB/GYN Care, LLC ("Associates"), a practice that provides abortion services at offices located in Baltimore, Frederick, Cheverly and Silver Spring.

3. The Respondent subsequently requested a hearing before the Board to address the Order. On August 28, 2013, the Board convened a show cause hearing for this purpose.

4. Pursuant to a letter dated August 29, 2013, the Board vacated the Order subject to the following condition: "Dr. Dominy . . . is prohibited from performing any procedures that require Dr. Dominy to administer sedation to patients."

5. The Respondent's license to practice medicine in the State of Maryland is currently active subject to the above condition and is scheduled for renewal on September 30, 2014.

Board investigation

6. The Board initiated an investigation of the Respondent and other physicians at Associates after reviewing licensing and disciplinary actions the Maryland Office of Health Care Quality ("OHCQ")[1] took against Associates.

7. The Respondent began practicing at Associates' four clinics in or around April 2012, where she performed medical and surgical abortions and provided other medical services.

8. OHCQ inspected Associates' surgical abortion facilities in or around February 2013, to evaluate its compliance with the State's surgical abortion clinic

[1] OHCQ licenses and certifies state health care facilities and monitors the quality of care in those facilities. OHCQ monitors state health care facilities under its jurisdiction to ensure compliance with all applicable state and federal regulations.

regulations (hereinafter "State regulations) under COMAR 10.12.01.01 *et seq.* OHCQ inspectors found that there were numerous deficiencies in Associates' operations and determined that it engaged in systemic violations of State regulations.

9. OHCQ found, *inter alia*, that Associates' Cheverly facility was in violation of State regulations because (a) the pads of its Automated External Defibrillator ("AED") expired in 2008; (b) the clinical nurse on site did not know how to use the AED and suction machine; (c) the District Manager admitted to the surveyor that the nurses had not been trained on the use of the AED and suction machine; (d) the suction machine did not work because an adapter was missing; (e) the facility failed to ensure that all staff had certification in basic life support; (f) the facility failed to ensure that there was a functional laryngoscope available in the procedure room when general anesthesia is administered; and (g) the facility failed to maintain a safe, functional and sanitary environment.

10. OHCQ found, *inter alia*, that Associates' Baltimore facility was in violation of State regulations because the facility failed to (a) ensure that all licensed staff were trained to use the AED; (b) ensure that the facility's emergency equipment had had preventative maintenance performed; (c) ensure that all licensed facility staff have certification in basic life support; (d) identify and discard expired medications; (e) ensure that the facility's medical records included a discharge diagnosis; and (f) ensure that the facility has a safe, functional and sanitary environment.

11. OHCQ found, *inter alia*, that Associates' Silver Spring facility was in violation of State regulations because the facility failed to (a) develop policies and procedures for pertinent safety practices; (b) ensure that the facility complied with its

policies on preventative maintenance of emergency equipment; (c) provide appropriate post-anesthesia care and observation to a patient; (d) ensure that all licensed facility staff have certification in basic life support; (e) provide appropriate emergency training for patient transfers to the hospital to seven employees; and (f) failed to develop a policy and procedure for the confidentiality of medical records.

12. During the survey, OHCQ investigators investigated the circumstances surrounding two incidents that occurred at Associates in or around February 2013, in which physicians at Associates left patients unattended after procedures.

13. One of the incidents involved the circumstances surrounding an abortion the Respondent performed on February 13, 2013, at the Baltimore office.[2] OHCQ investigators found that the Respondent, who had administered conscious sedation and performed an abortion on a woman who was then in her late 30s ("Patient A"),[3] left the patient with a medical assistant for a period of time. Patient A reportedly became hypoxic, after which the Respondent, who was not currently certified in basic life support, performed resuscitation efforts. Associates' staff contacted emergency services, which transported Patient A to a nearby hospital where she died on February 15, 2013. According to OHCQ records, Patient A died of severe pulmonary edema, acute respiratory distress syndrome and hypoxic brain injury.

14. After considering these findings, the Secretary of the Department of Health and Mental Hygiene summarily suspended the licenses of Associates' Baltimore,

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[2] The other incident involved another staff physician ("Physician A," ***infra***), who left a patient unattended after administering conscious sedation and performing an abortion at the Silver Spring clinic on February 26, 2013.

[3] To ensure confidentiality, the names of patients, staff persons and physicians, other than the Respondent, will not be used in this charging document. The Respondent may obtain the identity of any individual referenced herein by contacting the assigned administrative prosecutor.

Cheverly and Silver Spring offices, concluding that there was a threat to the public health and safety.

15. The Secretary subsequently lifted the suspensions of the clinics' licenses pending Associates' submission of acceptable written correction plans.

16. In or around the end of March 2013, the Respondent reportedly stopped practicing at Associates' Baltimore clinic due to scheduling and equipment failure issues but continued performing abortions at Associates' other three clinic locations.

17. Because of the above violations of State regulations, the OHCQ summarily suspended the licenses of all four of Associates' locations on or about May 9, 2013.[4]

18. On June 5, 2013, OHCQ filed a Notice of Intent to Revoke Surgical Abortion Facility Licenses against all four of Associates' clinic locations.

19. Based on Board investigation, which included a peer review of the Respondent's treatment of Patient A and an additional five patients, the Board found that the Respondent, with respect to Patient A, failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), for reasons including but not limited to the following:

(a) The Respondent failed to obtain proper informed consent from Patient A, who did not speak English or Spanish;

[4] On August 29, 2013, the Board vacated the summary suspension imposed on Dr. Dominy, but ordered that she was prohibited from performing any procedures requiring her to administer sedation to patients. This Consent Order supersedes the Board's August 29, 2013, order.

(b) The Respondent failed to perform and document a pre-operative physical examination of Patient A that included cardiac and pulmonary examinations;

(c) The Respondent failed to evaluate and document Patient A's pre-operative oxygenation status;

(d) The Respondent failed to undertake and document appropriate intra-operative monitoring, such as Patient A's vital signs, oxygen saturation levels or end tidal CO^2 levels during the procedure;

(e) The Respondent failed to have medications, such as reversal agents, available, when providing conscious sedation to Patient A;

(f) The Respondent failed to administer any reversal agents post-operatively to Patient A;

(g) The Respondent was not certified in basic life support when treating Patient A;

(h) The Respondent failed to use or have available an automated external defibrillator when providing post-operative care to Patient A;

(i) The Respondent failed to perform cardiopulmonary resuscitation appropriately when providing post-operative care to Patient A; and

(j) The Respondent inappropriately left Patient A unattended after the conclusion of the surgical procedure.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent violated the following provisions of the Act: H.O. § 14-404(a)(3), Is

guilty of: (ii) Unprofessional conduct in the practice of medicine; and 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.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is hereby

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

ORDERED that Respondent shall maintain Advanced Cardiac Life Support ("ACLS") certification as provided by the American Heart Association and shall provide the Board with verification of her ACLS certification; and it is further

ORDERED that the Respondent is placed on **PROBATION**, to commence on the date the Board executes this Consent Order, and continuing until she successfully complies with the following probationary terms and conditions:

1. The Respondent shall successfully complete at least sixteen (16) Category I continuing medical education ("CME") credit hours in moderate sedation and monitoring practices involving moderate sedation. The Respondent shall submit written documentation to the Board regarding the particular courses she proposes to fulfill this condition. The Board reserves the right to require the Respondent to provide further information regarding the courses she proposes, and further reserves the right to reject her proposed courses and require submission of an alternative proposal. The Board will approve a course only if it deems the curriculum and the duration of the course adequate to satisfy its concerns. The Respondent shall be responsible for submitting written documentation to the Board of her successful completion of the course(s). The

Respondent understands and agrees that she may not use this coursework to fulfill any requirements mandated for licensure renewal. The Respondent shall be solely responsible for furnishing the Board with adequate written verification that she has completed the course(s) according to the terms set forth herein;

2. The Respondent shall practice according to the Maryland Medical Practice Act and in accordance with all applicable laws, statutes, and regulations pertaining to the practice of medicine; and

3. If the Respondent has complied with the terms and conditions of probation, the Board will terminate the probation administratively upon the Board's receipt of written verification of the completion of the sixteen (16) CME credit hours of moderate sedation and monitoring course(s); and it is further

ORDERED that upon completion of sixteen (16) Category I CME credit hours referenced above in Probation Condition One (1), the Respondent shall submit to the Board for approval a written plan for sedation monitoring. The Respondent shall not administer anesthesia (moderate or deep sedation) until the Board approves her sedation monitoring plan; and it is further

ORDERED that if the Board approves the Respondent's sedation monitoring plan, the Respondent may administer moderate sedation in practice settings approved by the Board, and the Respondent shall comply with the Board-approved sedation monitoring plan; and it is further

ORDERED the Board reserves the right to conduct a peer review by an appropriate peer review entity, or a chart review by a Board designee, to be determined at the discretion of the Board; and it is further

ORDERED that if the Respondent violates any of the terms or conditions of probation or this Consent Order, the Board, after notice, opportunity for a hearing and determination of violation, may impose any other disciplinary sanctions it deems appropriate, including a reprimand, probation, the revocation or suspension of the Respondent's medical license, and/or fine, said violation being proven by a preponderance of the evidence; and it is further

ORDERED that the charges under H.O. § 14-404(a)(18)(Practices medicine with an unauthorized person or aids an unauthorized person in the practice of medicine) and under COMAR 10.32.12.04(Scope of Delegation) and COMAR 10.32.12.05(Prohibited Conduct) are hereby **DISMISSED**; and it is further

ORDERED that the Respondent shall not apply for early termination of probation; and it is further

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

ORDERED that the Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't. Code Ann. § 10-611 *et seq.* (2009 Repl. Vol. and 2013 Supp.).

10/23/13
Date

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

CONSENT

I, Iris E. Dominy, M.D., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I agree and accept to be

bound by this 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 this 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.

10·15·13
Date

Iris E. Dominy, M.D.
Respondent

Read and approved by:

Kevin A. Dunne, Esquire
Counsel for Dr. Dominy

NOTARY

STATE OF Maryland

STEVE FUENTES
NOTARY PUBLIC
MONTGOMERY COUNTY
MARYLAND
MY COMMISSION EXPIRES JANUARY 18, 2016

CITY/COUNTY OF: Montgomery

I HEREBY CERTIFY that on this 15 day of October, 2013, before me, a Notary Public of the State and County aforesaid, personally appeared Iris E. Dominy, 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.

Notary Public

My commission expires: 1/18/2016

STEVE FUENTES
NOTARY PUBLIC
MONTGOMERY COUNTY
MARYLAND
MY COMMISSION EXPIRES JANUARY 18, 2016