IN THE MATTER OF	*	**BEFORE THE MARYLAND**
ROBERT F. HOOFNAGLE, Jr., M.D.	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D35873	*	**Case Numbers: 2011-0012 & 2012-0611**

****

CONSENT ORDER

On December 12, 2012, the Maryland State Board of Physicians (the "Board"), charged Robert F. Hoofnagle, Jr., M.D. (the Respondent") (D.O.B. 03/27/1959), License Number D35873, under the Maryland Medical Practice Act (the "Act"). Md. Health Occ. Code Ann. ("Health Occ.") § 14-101 et seq. (2009 Repl. Vol.).

The pertinent provisions of the Act provide the following:

§ 14-404. Denials, reprimands, probations, suspensions, and revocations -- Grounds.

(a) *In general.* -- Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

(3) Is guilty of:

...

(ii) 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;

(33) Fails to cooperate with a lawful investigation conducted by the Board;

(40) Fails to keep adequate medical records as determined by appropriate peer review [.]

On April 3, 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, consisting of Findings of Fact, Conclusions of Law, and Order.

I. FINDINGS OF FACT

BACKGROUND AND GENERAL FINDINGS

1. At all times relevant hereto, the Respondent was licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on October 5, 1987.

2. At all times relevant to these Charges, the Respondent, a board-certified urologist, was in private practice in Belair, Maryland, and held privileges at two Baltimore area hospitals, identified for purposes of this document as Hospitals A and B.[1]

MBP Case # 2011-0012

3. On or about July 13, 2010, the Board received an anonymous complaint alleging the Respondent had appeared impaired while in the operating room.[2] Additionally, the complainant alleged that in February 2009, a 9 year-old patient (identified as "Patient A") died following surgery for an undescended testicle. (Case # 2011-0012)

[1] In order to maintain confidentiality, facility and patient names will not be used in this document.
[2] Hospital A conducted an investigation of the allegations of impairment and was unable to substantiate that the Respondent had been impaired.

4. On or about September 27, 2010, the Board notified the Respondent of its investigation, and on October 22, 2010, he filed a written response with the Board indicating that diagnosed medical conditions may have caused concern regarding his appearance.

5. By letter dated October 5, 2010, the Board issued a Subpoena *ad testificandum* for the Respondent to appear for an interview with the Board's staff on October 28, 2010.

6. On or about October 22, 2010, the Respondent filed a written response to the anonymous complaint sent to the Board.

7. On or about November 16, 2010, the Board's staff conducted an interview under oath with the Respondent.

8. On or about April 20, 2012, in furtherance of its investigation of Patient A, the Board transmitted patient records and other relevant documents to Permedion, a peer review organization, requesting that a peer review be conducted. The results of the peer review are set forth below.

9. On or about July 23, 2012, the Board sent the Respondent copies of the peer review reports and offered him an opportunity to file a supplemental response with the Board.

10. On or about August 8, 2012, the Respondent filed with the Board a supplemental response to the peer review report.

FINDINGS OF FACT RELATING TO CASE # 2011-0012

11. On or about July 2, 2010, Hospital A's operating room staff reported to the administrative staff that the Respondent appeared to be behaving abnormally

and may been potentially impaired. Hospital A conducted an investigation of the allegations of impairment in the operating room, including a urine toxicology screen, and was unable to substantiate that the Respondent had been impaired. The administrative staff did, however, require that the Respondent submit to toxicology screening for a period of twelve months if cause arose, and that he consent to the administrative staff communicating with and reviewing records and evaluations from the Respondent's treating physicians.

PEER REVIEW

12. Patient A was a 9 year-old male who presented in October 2008 with undescended left testis. According to Patient A's mother, prior to a swing accident, the testis had been in a normal position. An ultrasound study showed a retracted left testicle, inguinal in location.

13. On December 18, 2008, the Respondent performed an elective orchiopexy on Patient A.

14. During Patient A's surgery, the Respondent had difficulty performing the surgery and entered Patient A's bladder on two occasions. The Respondent's operative report reflects that he was confused concerning Patient A's anatomy.[3]

15. The Respondent placed a Jackson Pratt ("JP") drain and a foley catheter ("catheter").

16. The Respondent discharged Patient A from the hospital on December 22, 2008, the fourth postoperative day.

[3] The Respondent characterized Patient A's anatomy as "abnormal" and "all over the place" during his January 16, 2010 interview with the Board's staff.

17. On December 29, 2008, the Respondent saw Patient A for a postoperative follow-up visit and removed his JP drain.

18. The Respondent failed to dictate Patient A's operative report until January 4, 2009.[4]

19. On January 5, 2009, Patient A had a cystogram that showed extraperitoneal extravasation (leakage outside the peritoneal cavity).[5] The Respondent's plan was to leave Patient A's foley catheter in place for an additional two weeks and to repeat the cystogram.

20. After Patient A's cystogram on January 6, 2009, the catheter fell out. Subsequently, the Respondent decided not to replace the catheter since Patient A had reported he was voiding without pain.

21. The standard of quality care required that the Respondent replace the catheter as originally planned, and leave it in place for an additional two weeks.

22. On January 12, 2009, Patient A reported burning on urination; a urine culture tested 25,000-50,000 pseudomonas colonies. The Respondent prescribed Bactrim.[6] The Respondent failed to order a repeat urine culture.

23. The Respondent noted in his supplemental response that the home health nurse notified him there was a small fluid collection at the end of his inguinal incision.

24. On January 14, 2009, Patient A had a sonogram that showed either postsurgical fluid anterior to the bladder or a small urinoma, and possible continued extravasation. The radiologist recommended that, "a contrast enhanced CT scan

---

[4] Hospital A's medical record completion policy required that operative notes for procedures performed in the OR be dictated by the day following the procedure.

[5] The Respondent stated this was because the radiologist had manually injected the contrast dye against his instructions.

[6] Bactrim may be resistant to pseudomonas.

of the abdomen may be more helpful for further evaluation to evaluate an active leak from the urinary bladder." The Respondent failed to order the CT scan of the abdomen with contrast.

25. On February 5, 2009, Patient A developed a sore throat and a temperature to 103°. Initially, Patient A saw his primary care provider who prescribed Amoxicillin, and cancelled his appointment with the Respondent.

26. Patient A began vomiting on February 5, 2009, and had increased vomiting on February 10, 2009.

27. On February 11, 2009, Patient A had a seizure at home, and was taken to the emergency room at Hospital A, had a cardiac arrest and expired.

28. According to the autopsy report results, Patient A died secondary to acute pyelonephritis.

29. The peer reviewers concurred that the Respondent failed to deliver quality medical and surgical care to Patient A in violation of Health Occ. § 14-404(a)(22) and that he failed to keep adequate medical records in violation of Health Occ. § 14-404(a)(40).

II. CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's actions and inactions as outlined above constitute violations of Md. Health Occ. Code Ann. § 14-404(a) (22) and (40). The Board agrees to dismiss: 1) the charges of unprofessional conduct in the practice of medicine pursuant to Health Occ. § 14-404(a)(3)(ii) and 2) fails to cooperate with a lawful investigation conducted by the Board pursuant to Health Occ. § 14-404(a)(33).

III. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, a majority of the quorum of the Board considering this case, hereby

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

ORDERED that this Consent Order shall be a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 et seq. (2009 Repl. Vol. & 2012 Supp.).

May 22, 2013
Date

Carole J. Catalfo, Executive Director
Maryland State Board of Physicians

CONSENT ORDER

I, Robert F. Hoognagle, Jr., M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the 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 might have followed 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.

April 23, 2013
Date

Robert F. Hoognagle, Jr., M.D.

Reviewed and Approved by:

Sarah Marquardt, Esquire

STATE OF MARYLAND
CITY/COUNTY OF Harford

I HEREBY CERTIFY that on this 23 day of April, 2013, before me, a Notary Public of the foregoing State and City/County personally appeared Robert F. Hoognagle, Jr., M.D., License Number D35873, 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.

Janet S. McMillan
Notary Public

Commission expires: March 8, 2014