IN THE MATTER OF	*	BEFORE THE
BARRY J. COHEN, M.D.	*	MARYLAND STATE BOARD
Respondent	*	BOARD OF PHYSICIANS
License No.: D37723	*	Board Case No.: 2009-0867

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FINAL DECISION AND ORDER

On July 18, 2011, the Maryland State Board of Physicians (the "Board") charged Barry J. Cohen, M.D., a plastic surgeon, with failing to keep adequate medical records as determined by appropriate peer review, *see* Health Occ. § 14-404(a)(40), regarding three patients ("Patient 2," "Patient 4," and "Patient 6"). On April 18-19, 2012, an evidentiary hearing was held before an Administrative Law Judge ("ALJ") at the Office of Administrative Hearings. On June 25, 2012, the ALJ issued a proposed decision recommending that the Board dismiss the charges. The State took exception to the ALJ's proposed decision. Dr. Cohen filed a response to the State's exceptions. On October 24, 2012, the Board heard oral argument from both parties concerning the State's exceptions.

After carefully considering the State's exceptions, Dr. Cohen's response, the oral arguments, and the evidentiary record in this case, the Board has determined that Dr. Cohen violated section 14-404(a)(40), by failing to keep adequate medical records.

Dr. Cohen's documentation of the initial visits of the three patients at issue, found in his handwritten Office Notes, was extremely lacking. Patient 2 visited Dr. Cohen because of a basal cell carcinoma on her nose. In removing the basal cell carcinoma and reconstructing Patient 2's nose, Dr. Cohen operated on the patient four times. Dr. Cohen's note of the patient's first visit states, in full:

135/91 91
71 y/o [illegible]
BCC[1] nose
Rec[2]: staged
Excision & recon – late

Patient 4 visited Dr. Cohen for a rhinoplasty. Dr. Cohen's note from the initial visit states, in full:

110/84 P70
C/o nose – too wide
rec: - nasal shell medpor
- Weir[3]
Medial /lat osteotomies[4]
Open

Patient 6 visited Dr. Cohen for a revision of a rhinoplasty and for a lip augmentation. Dr. Cohen's note from the initial visit states, in full:

S/P Rhino. c/o
Nose
Rec: revision rhino
Lat osteotmies
Thin columella
Medial osteotomies
Revise tip

Lip Aug 5mm Advante round

Dr. Cohen failed to adequately document three essential categories of information concerning the initial visits of the three patients at issue in this case: (1) the patients' underlying conditions; (2) the patients' medical histories; and (3) Dr. Cohen's findings from his own evaluations of the patients (including failing to identify the evaluations he conducted). But,

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[1] Basal cell carcinoma.
[2] Recommendation.
[3] Weir ala excision.
[4] Medial and lateral osteotomies refer to the cutting of the nasal bones.

while Dr. Cohen's notes from the patients' initial visits have concerned the Board the most, inadequacies in his documentation can also be found elsewhere in the record.

The ALJ based her proposed decision upon the testimony of Gary Brandon Burton, M.D. and Nelson Howard Goldberg, M.D., expert witnesses who testified on behalf of Dr. Cohen. The essence of the ALJ's proposed decision and the testimony of Dr. Burton and Dr. Goldberg was that, while Dr. Cohen's initial notes were sparse, the records when combined, or "in their totality," were sufficient. The ALJ and Dr. Cohen's experts felt that photographs taken of the patients were especially valuable in providing information missing from Dr. Cohen's notes. The Board is not persuaded. The Board finds the testimony of the State's experts, Terri L. Hill, M.D. and Michael P. Vincent, M.D.,[5] who found Dr. Cohen's documentation inadequate, more persuasive.

Even if one relied, in this case, upon the records in their totality, including the photographs, there was still significant information missing. In any case, relying upon the overall medical file to substitute for information that should be contained in the initial note is untenable. Records produced later may eventually cumulatively fill in the missing pieces, but, until those later records are produced, the record is incomplete. And one should not have to review the entire file to obtain information that should be in the initial visit note. The initial visit establishes the direction of the patient's treatment, and a patient's subsequent treatment may take place over the course of years. Patient 6 saw Dr. Cohen over 25 times over the course of four years. On the initial visit, it is essential to document, in detail, the patient's condition and the reasons for the planned treatment.

[5] Dr. Hill and Dr. Vincent also conducted peer reviews for the Board.

Concerning Patient 2, Dr. Cohen failed to document how long the patient's basal cell carcinoma had been present (or any changes in its appearance), failed to record whether the patient had any history of cancer or other or previous skin lesions, failed to document whether the patient had any other symptoms, and failed to describe or measure the basal cell carcinoma. Additionally, the operative note for the initial surgery excising the basal cell carcinoma stated that the "patient also had 2 lesions excised." There is no explanation in the medical records as to what two lesions Dr. Cohen was referring to. And the records fail to document what occurred between November 20, 2008, and the patient's fourth surgery by Dr. Cohen on February 25, 2009.

When Patient 4 initially visited Dr. Cohen, he wrote that the patient thought that her nose was "too wide." Dr. Cohen should have described what anatomic subunits of the nose were too wide. Also, Dr. Cohen should have documented whether surgery upon the patient's nose was purely cosmetic or whether the patient had legitimate medical concerns, such as breathing or airway problems. Regardless, Dr. Cohen should have documented a baseline functional exam on the patient's breathing, which would be used later to determine whether the surgery had affected the patient's breathing.

The reason for the patient's surgery should be clear from the medical record. Concerning Patient 6's initial visit, Dr. Cohen's initial note suggests that the patient had a complaint about her nose from a previous rhinoplasty. But the note does not explain when the initial rhinoplasty took place, why she had the initial rhinoplasty, whether the initial rhinoplasty was inadequate, or what the patient wanted revised. And again, Dr. Cohen does not mention whether the patient had any problems with her nose other than its appearance. And Dr. Cohen's note does not even state

that the patient had a complaint about her lip. Dr. Cohen's initial note concerning the patient's lip simply states, "Lip Aug 5mm Advante round."

In documenting the patients' histories and physicals, Dr. Cohen relied almost exclusively upon the patients filling out medical forms and the evaluations and reviews performed by the nurse anesthetists, but there is no documentation that Dr. Cohen reviewed the medical forms filled out by the patients and nurse anesthetists. Patient 4 checked "yes" for "Lung disease (asthma, emphysema, etc.)" on an undated Pre-Anesthesia Form, but there is no comment or note from Dr. Cohen or any other physician regarding this condition. Patient 4's medical records contain her pre-operative blood testing laboratory results (December 6, 2008), which was initialed by the nurse anesthetist, but not Dr. Cohen. Likewise, Patient 4's Surgery & Anesthesia History has several notes on it by the nurse anesthetist, but not by Dr. Cohen.

Dr. Cohen's documentation was inadequate, in violation of section 14-404(a)(40) of the Health Occupations Article.

FINDINGS OF FACT

The findings of fact were proven by the preponderance of the evidence.

Dr. Cohen was originally licensed to practice medicine in Maryland in 1988. Dr. Cohen has continually renewed and maintained a Board license to practice medicine in Maryland. Since 1995, Dr. Cohen has been certified by the American Board of Plastic and Reconstructive, and, in 2004, he received lifetime board-certification.

Dr. Cohen has been a partner in the group practice Washington Plastic Surgery Group, LLC. The practice has maintained three offices, two in Maryland (Rockville and Annapolis) and one in Virginia (McLean). The events in this case took place in Rockville, Maryland.

PATIENT 2

Patient 2, a 71 year old female, was first seen by Dr. Cohen on October 17, 2008, concerning a basal cell carcinoma on her nose. The patient filled out and signed the initial information form and wrote basal cell carcinoma as the reason for her visit. The patient also filled out a Health History Form listing her medications and also checked the medical conditions applicable to her (back pain, dentures, high blood pressure). The patient also checked on the form that she had surgery before. Dr. Cohen met with the patient and on the Office Notes, under the patient's name and the date, handwrote and signed the following note:

135/91 91
71 y/o [illegible]
BCC nose
Rec: staged
Excision & recon – late

Photographs of Patient 2 were taken at this visit to record the pre-operative appearance of the basal cell carcinoma on her nose. An excision of Patient 2's basal cell carcinoma was scheduled for October 31, 2008.

On October 31, 2008, Patient 2 arrived at the surgical center and filled out a Health and Physical History form. On this form, Patient 2 answered that she had had surgery before, but she did not respond to the question asking what type of surgery she previously had. On the Health and Physical History form Dr. Cohen filled in the following:

HEENT[6]: Basal Cell CA Nose
LUNGS: CTA [Clear To Auscultation]
CVS[7]: NSR [Normal Sinus Rhythm]
CNS[8]: MS [Mental Status] WNL [Within Normal Limits]

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[6] Head, Ears, Eyes, Nose, and Throat.
[7] Cardiovascular System.
[8] Central Nervous System.

Patient 2 also signed an informed consent form, and she filled out and signed a Pre-Anesthesia form, which is undated. The patient checked "yes" for high blood pressure and dentures and signed the form. There is a section on the form for physician comments, which was not filled out. The informed consent form stated that the procedure was for the "Removal of BCC from nose." Dr. Cohen then performed the excision of Patient 2's basal cell carcinoma. After the surgery, Dr. Cohen handwrote a Brief Operative Note, stating he removed the basal cell carcinoma and sections were collected from the excision wound for margin testing. Two weeks later, on November 14, 2008, Dr. Cohen dictated an Operative Report (which was transcribed on November 14, 2008), stating:

BARRY J. COHEN, M.D., P.C.

Operative Report

Date:	October 31, 2008
Patient:	[Patient 2]
Location:	The Surgery Center of Potomac
Surgeon:	Cohen
Preoperative Diagnosis:	Basal cell carcinoma of nose.
Postoperative Diagnosis:	Basal cell carcinoma of nose.
Procedure:	Reconstruction of nose.

Indications for the Procedure: This is a white female who came in today for the above-noted procedure. Risks and complications were reviewed with the patient preoperatively, these include, but not limited to infection, bleeding, scars, and recurrence.

Description of the Procedure: The patient was brought to the operating room. She was anesthetized with total of 10 cc of 1% Xylocaine with adrenalin mixed with Wydase. The patient underwent an excision of the area of her nose with wound debridement. The nasal labial fold flap was elevated. Cheek flap was also elevated for a subsequent advancement to closure. The wounds were closed with #3-0 Monocryl suture and #4-0 Monocryl suture as well as #5-0 nylon sutures. The patient tolerated the procedure well.

Plan: She was discharged to the recovery room. The patient also had 2 lesions excised with hifurcation.[9] She was discharged to recovery and then to home in stable condition to office followup.

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[9] The Board does not know what "hifurcation" is, thus, the Board believes this word was mistranscribed. And the Board could only speculate as to what this word should have been, because the Board does not know what "2 lesions" Dr. Cohen is referring to.

[Dr. Cohen's signature]
Barry J. Cohen, M.D., F.A.C.S., P.C.
Diplomate, American Board of Plastic Surgery
Dictated but not read.

BC/pv D: 11/14/2008 T: 11/15/2008

On November 3, 2008, the results from the testing returned, finding positive margins, meaning cancer cells remained at the margins of the excision: "Diagnosis: Basal cell carcinoma, focally extending to lateral margins (12-3 o'clock and 9-12 o'clock, see gross). Deep margin is negative for carcinoma." Thus, surgery was scheduled for the following day to remove the remaining cancer cells.

On November 4, 2008, Dr. Cohen performed a re-excision of the nose to remove the remaining cancer cells. Dr. Cohen also collected further sections for testing. On November 6, 2008, Dr. Cohen dictated an operative report, which was transcribed on November 10, 2008, and which states:

Operative Report

Date:	**November 4, 2008**
Patient:	[Patient 2]
Location:	The Surgical Center of Potomac
Preoperative Diagnosis:	Persistent basal cell carcinoma of the nose
Postoperative Diagnosis:	Persistent basal cell carcinoma
Procedure:	Re-excision of nose

Indication for the Procedure: This is a white female who came in today with positive margins from her excision last week. The patient was made aware that this might be necessary.

Description of the Procedure: The event of positive margins the area that was positive between the superior border between the 3 and the 9 o'clock position. This was resected for approximately 2-3 mm. The specimen was marked with a silk suture at the superior margin. This was sent for pathologic re-evaluation. The patient's wounds were cauterized, Gelfoam, Xeroform and Steri-Strips were placed.

She tolerated the procedure well.

Plan: She was discharged to the recovery room and then to home in stable condition. Office followup.

[Dr. Cohen's signature]
Diplomate, American Board of Plastic Surgery
Dictated but not read.

BC/cp D: 11/6/2008 T: 11/10/2008

On November 6, 2008, Patient 2 returned, and Dr. Cohen reconstructed the patient's nose. Before the surgery, the patient completed a Health and Physical History Form (high blood pressure, dentures, previous surgery). On the Health and Physical History Form, Dr. Cohen filled out the following:

HEENT: Defect
LUNGS: CTA
CVS: NSR
CNS: MS WNL

Patient 2 signed an informed consent form for "Nose reconstruction with flap closure." In addition, a list of the patient's medications was typed. Photographs of the patient's face were also taken before the surgery. Dr. Cohen then performed the nose reconstruction, which entailed an elevation of a nasal labial fold flap. No sections for testing were collected. Afterward Dr. Cohen handwrote a Brief Operative Note, stating, in relevant part, "basal cell" and "nose reconstruction with flap closure." A pre-procedure and post procedure form was not filled out, but "Dictated" was written across the form. Dr. Cohen did dictate a detailed operative report. The transcribed operative report neither states when it was dictated or when it was transcribed. A physician assistant wrote a discharge summary.

The pathology report concerning the sections collected during the November 4, 2008, surgery was completed on November 7, 2008, indicating that the surgical margins were clear, although, on one step section, residual basal cell carcinoma was seen. Also, on November 7, a nurse called the patient to determine if there were any post-op concerns. This call was documented in the medical file.

On November 13, 2008, the patient visited Dr. Cohen's office, and her sutures were removed. Dr. Cohen met with the patient and said that he would like to see the patient in six weeks to discuss using "5-FU Dex" to try and prevent future skin cancer. Photographs of the patient were taken. On November 20, 2008, the physician assistant dictated an office visit note of the November 13 visit, which was transcribed on November 21, 2008.

On February 25, 2009, Patient 2 returned to the surgery center for further reconstructive surgery. The medical file does not contain any records indicating what occurred between November 13, 2008, and February 25, 2009. On February 25, Dr. Cohen performed a revision inset of tube pedicle flap. On March 2, 2009, Dr. Cohen dictated an operative report, which was dictated on March 3, 2009, and later signed by him. According to the operative report, the "patient came in [on February 25] for division inset of the flap. . . . The patient underwent elevation of the inferolateral segment of the flap. This was debulked and inst. The inset was done with a #5-0 Vicryl suture and a #6-0 fast-absorbing gut suture. . . . She was discharged to home on oral antibiotics and pain meds for office followup."

On May 18, 2009, the patient returned to the office with a complaint of localized swelling at the nostril and nasal ala. The physician assistant handwrote an office note. According to the office note, photographs were taken and Kenalog 10 was injected into the swelling. The patient was encouraged to massage the scar and follow-up in six weeks.

There were no further medical records in Dr. Cohen's file of the patient.

PATIENT 4

On September 8, 2008, Patient 4, a 27 year old female, first visited Dr. Cohen. The patient was inquiring about a rhinoplasty and breast augmentation. The patient filled out and signed a Health History Form checking "Hepatitis." The patient did not list any medications in

the medication section. The patient also checked "No" for whether she had had any prior surgeries. The medical records also have a Pre-Anesthesia Form filled out and signed by the patient, but the form has no date. The patient checked "Yes" for "Lung disease (asthma, emphysema, etc.)" and "Thyroid problem." Under Medications, the patient wrote "Thyroid." The form has a physician comments section, but nothing is written in this section. Dr. Cohen met with Patient 4 and on the Office Notes, under the date and patient's name, handwrote and signed the following note:

110/84 P70
C/o nose – too wide
rec: - nasal shell medpor
- Weir
Medial /lat osteotomies
Open

The office note does not refer to a breast augmentation. Dr. Cohen also wrote a prescription for the patient for pre-operative blood testing. Dr. Cohen then sent a letter, dated September 8, 2008, to the patient, describing his professional background, the risks and complications of rhinoplasty and breast augmentation, pre-surgery requirements (no aspirin or certain vitamins immediately prior to surgery), the fees, payment schedule, and financial penalty for cancelling the surgery. The rhinoplasty was scheduled for December 9, 2008.

On December 5, 2008, the patient may have had an office visit with Dr. Cohen.[10] The medical file does not contain a medical record documenting a visit. The medical file does, however, have a letter, dated December 5, 2008, from Dr. Cohen to Patient 4, which describes the risks and complications of rhinoplasty, the pre-operation instructions for the patient, and the fee schedule. The letter is signed by both Dr. Cohen and the patient. Also on December 5, 2008,

[10] The ALJ found that "[o]n December 5, 2008, Patient 4 returned to the Respondent for an office visit to plan a rhinoplasty to make her nose less wide and insert a small implant in the tip of her nose."

the patient went to LabCorp for pre-operative blood testing. The blood testing was completed on December 6, 2008, and the results were faxed to Dr. Cohen.

On December 9, 2008, Patient 4 arrived at the Surgery Center of Potomac for the rhinoplasty and nose implant. The patient filled out, signed, and dated a Surgery & Anesthesia History and Physical. The patient checked a history of thyroid disease and wrote "none" for current medication. The CRNA, however, wrote "synthroid q day – took it yesterday." The CRNA wrote "thyroidectomy" for Post Surgical History/Hospitalization. The patient also wrote that her last anesthesia was three years ago and "No" for complications. The CRNA, however, wrote "GA [general anesthesia] postop N&V [nausea and vomiting]," concerning previous anesthesia. The patient, Dr. Cohen, and the certified nurse anesthetist signed an informed consent form for "Rhinoplasty with Medpor shell." The Office Notes state, "OK for GA DAD [initials of the nurse anesthetist]." Pre-operative photographs were taken of the patient. A Surgery & Anesthesia History & Physical form was signed by Dr. Cohen and the nurse anesthetist. The form had a check for "Nasal deformity – Circle (deviated, septum, nasal obstruction), but no circle was entered. The form had the patient's vital signs documented under Physical Examination and General Anesthesia circled. The record also has a pre-operative checklist signed by a nurse; an intraoperative record given by the nurse anesthetist; an anesthesia record; postoperative nursing notes; anesthesia orders and a discharge assessment; a Brief Operative Note (post procedure diagnosis: Nasal deformity; procedure performed and finding: rhinoplasty with Medpor Shell), signed by Dr. Cohen; a PACU Record; a handwritten discharge summary stating Rhinoplasty [with] Medpor Shell; a detailed and typed Rhinoplasty Post Op Discharge Instructions form signed by patient, and list of post-operation prescriptions to address

complications signed by a nurse. The medical record also has the following operative report dictated by Dr. Cohen on December 15, 2008, and transcribed on December 17, 2008:

BARRY J. COHEN., P.C.

Operative Report [Name, date, address, patient Number, telephone number, and date of birth of patient]

Date:	December 9, 2008
Patient:	[Patient 4]
Location:	The Surgery Center of Potomac
Preoperative Diagnosis:	Nasal deformity.
Postoperative Diagnosis:	Nasal deformity.
Procedure:	Rhinoplasty with Medpor nasal shell.

Indications for the Procedure: This is a [ ] female who came in today for the above-noted procedure. Risks and complications were reviewed with the patient preoperatively. These included (but were not limited to) infection, bleeding, scars, postoperative asymmetries, need for touchup, infection of new implant and bleeding or extrusion.

Description of the Procedure: The patient was brought to the operating room. She was prepped and draped in the usual standard fashion. She underwent an open rhinoplasty. The patient underwent tip refinement dorsal resection in medial osteotomies through the incision. Bilateral piriform incisions were made. Care was taken to spread the angular artery away from the incisions. A Joseph elevator was used to create pockets through which low-to-low osteotomies were performed. Pleasant infracturing was noted. The patient had a Medpor nasal shell soaked in antibiotic solution, which was placed into the nasal pocket and trimmed for appropriate sizing. A columellar strut from the same Medpor material was fashioned and placed between the medial crura of lower lateral cartilages and sewn in place using #4-0 Vicryl sutuure. The patient was noted to have a pleasing aesthetic profile 5mm of rear excisions were accomplished using calipers. The patient's wounds were closed with #4-0 Vicryl and #5-0 Prolene suture. The patient tolerated the procedure well.

Plan: She was discharged to the recovery room and then to home in stable condition for office followup.

MEDPOR® Surgical Implant
CAT # 9553 DIM 38x21x17
Nasal Shell Regular QTY :1
LOT D231G07

[Dr. Cohen's signature]
Barry J. Cohen, M.D., F.A.C.S., P.C.
Diplomate, American Board of Plastic Surgery

Dictated but not read.

BC/p*v D: 12/15/2008 T: 12/17/2008

On December 10, 2008, a nurse called the patient to see if there were any post-operative concerns. The phone call was documented on a Post-Op Telephone Call form.

On December 15, 2008, the patient returned to Dr. Cohen's office for a follow-up appointment. There is an office note handwritten by a physician assistant. According to the office note, the sutures were removed, and Dr. Cohen removed the nasal splint. The note also states that the patient had the expected amount of swelling.[11]

On January 8, 2009, the patient returned to the office for a follow-up appointment. The physician assistant handwrote wrote a note stating that Dr. Cohen injected the dorsum of the patient's nose with a mixture of Kenalog 10 and lidocaine. The note mentions that the patient had the expected swelling from the rhinoplasty from a month earlier.

On February 12, 2009, the patient visited the office for a follow-up appointment. A dictation of the visit was made by the physician assistant. According to the dictation, the patient had the expected amount of swelling, and a mixture of Kenalog 10 and lidocine was injected bilaterally into the patient's nose. Also, photographs of the patient were taken. The ALJ found that Dr. Cohen wrote the patient's vital signs on the office note.

On April 8, 2009, the patient visited the office for a follow-up appointment. The Office Notes have a note, which is handwritten and unsigned. The note contains the patient's blood pressure and pulse, states the patient is doing well, and "Arnica for bruising."

On July 15, 2009, the patient did not show for a visit. This was recorded in an office note.

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[11] The medical record has an Office Notes page that has notes for September 8, 2008, and December 9, 2008, and also has what appears to be the beginning of a note for presumably December 15, 2008, stating, "SCP rhinoplasty [with] MedPor." (BJC10882.) The Board assumes that this note for presumably December 15, 2008, was abandoned. The full, signed note for December 15, 2008, is also on an Office Notes page with the same notes for September 8, 2008, and December 9, 2008. (BJC10884.) Because the administrative record has only copies of the medical record, instead of the originals, it is difficult to discern which notes on these forms were copied. The Board finds this odd but not significant.

On October 14, 2009, the patient visited the office for a follow-up appointment. Dr. Cohen handwrote and signed an office note, which states, "looks fabulous for 10 mos. ½ cc Kenalog 10 to tip [ ] 3 mos."

On February 3, 2010, the patient failed to show for a follow-up appointment.

PATIENT 6

October 20, 2005, Patient 6, a 32 year old female, first arrived at the Washington Plastic Surgery Group inquiring about a lip augmentation and a revision of a previous rhinoplasty. She filled out a health history form listing recent cold, back pain, and dentures. The patient marked that she had had surgery previously: "Nose." The patient also filled out a Pre-Anesthesia Form, no date, and marked yes to "Loose or capped teeth or dentures in place" and that she smoked. Under medications, she wrote "DEPO." The form has a section for physician comments. There were no comments. Dr. Cohen met with the patient and on the Office Notes, under the date and patient's name, handwrote and signed the following note:

S/P Rhino. c/o
Nose
Rec: revision rhino
Lat osteotmies
Thin columella
Medial osteotomies
Revise tip

Lip Aug 5mm Advante round

On November 10, 2005, Dr. Cohen sent Patient 6 a letter, describing his background, the risks and complications of rhinoplasty, pre-surgery precautions, fee schedule, and notice as to when to arrive at the surgical center. The letter did not discuss lip augmentation. On November 15, 2005, the patient signed the form, acknowledging that she read and understood the letter.

The patient arrived for her surgery on November 22, 2005. The patient signed an informed consent form "Rhinoplasty lip augmentation with advanta 5mm." The patient also filled out a Pre-Anesthesia Form, marking "yes" for "Nausea/vomiting after surgery/anesthesia," "Are you pregnant now,"[12] and that she smokes one pack a week. The patient also wrote "lexapro" under medications, and that she was allergic to Percocet. The CRNA wrote comments in the physician comments section: "Smokes 1 pk/week," "Rhino," "Colonoscopy," GA [without] prob.," and family [history] prob. [with] [illegible]." The patient filled out a Health History Form, which also had a section to be completed by a physician. Dr. Cohen wrote in that section:

HEENT: Nasal / lip deformity
LUNGS: CTA
CVS: NSR
CNS: MS WNL

A nurse filled out the pre-operative checklist. Dr. Cohen performed the surgery and dictated the following Operative Report:

Operative Report

Date:	November 22, 2005
Patient:	[Patient 6]
Location:	The Surgery Center of Potomac
Preoperative Diagnosis:	1. This upper lip. 2. Status post rhinoplasty with too large nose.
Postoperative Diagnosis:	Same
Procedure:	1. Secondary rhinoplasty. 2. Augmentation of upper lip.

Indications for the Procedure: This is a female who came in today for the above noted procedure. The risks and complications were reviewed with the patient preoperatively. These include, but are not limited to, infection, bleeding, scars, postoperative asymmetries, need for touch up, infection of the implant leading to the necessity for removal, postoperative asymmetries of the nose leading to the necessity for revision, persistence of the nasal deviation.

[12] The Board finds that this was an error and that the patient instead meant to mark "yes" for "Loose or capped teeth or denture in place," because the patient wrote next to the "yes": "Permanent Bridge."

Description of the Procedure: The patient was brought to the operating room and prepped and draped in the usual standard and fashion. She was anesthetized with a total of 10 ccs of a 50/50 mixture of 1% Xylocaine with adrenaline and 0.25% Marcaine with adrenaline mixed with 1 cc of Wydase. After adequate anesthesia was achieved, bilateral intracartilaginous incisions were made. The remaining cephalic portion of the lower lateral cartilage was resected symmetrically. The patient's dorsum was further undermined and dorsal osteotomy was completed. Bilateral puriform incisions were made. Care was taken to spread the angular artery away from the incision. A Joseph elevator was used to create pockets for low-to-low osteotomies which were accomplished using curved silver osteotome. Pleasant in-fracture of the nose and straightening was noted. The patient had complained that her columella was too long. Just suberior to the lower lateral cartilages, the soft septum was resected for approximately 2 mm. The wounds were closed using 4-0 chromic suture. Mastisol and Steri-Strips were applied along with an Aquplast nasal splint. An Advanta lip implant was then placed using a 5 mm implant using a trocar. The wounds were then closed using 5-0 Prolene suture. The implant had been soaked in antibiotic solution prior to insertion. She tolerated the procedure well.

Plan: The patient was discharged to the recovery room and then to home in a stable condition on oral antibiotics and pain medicine to office follow-up.

[Dr. Cohen's signature]
Barry J. Cohen, M.D., F.A.C.S., P.C.
Diplomate, American Board of Plastic Surgery
Dictated but not read

BJC/nmh
cc: The Surgery Center of Potomac

The patient received post-op instructions and left the surgical center.

The next day, a nurse called the patient to see if there were any post-op concerns, which was recorded on a Post-Op Telephone Call form.

From November 29, 2005, to October 25, 2006, the patient had six follow-up visits documented by office notes. The notes state how the nose and lip were healing generally, whether Kenalog 10 was injected (including amount and location), and that there should be a follow-up. On October 25, 2006, a physician assistant wrote on the office notes "Wants tip revision." Dr. Cohen wrote "Schedule local [illegible] supratip revision."

On November 8, 2006, the patient arrived for surgery. She signed an informed consent form for nasal supratip revision. The patient also partially filled out and signed a Health History Form. An admission assessment was filled out by D. Duffer, ST. Of note, it states that the patient was given the following medications: "Keflex, Per[c]ocet, Medrol." Previously, on the November 22, 2005, Pre-Anesthesia form, the patient stated that she was allergic to Percocet. Dr. Cohen performed the surgery and dictated the following Operative Report:

Operative Report

Date:	November 08, 2006
Patient:	[Patient 6]
Location:	2nd floor treatment room
Preoperative Diagnosis:	Nasal deformity, status post rhinoplasty
Postoperative Diagnosis:	Same
Procedure:	Touch up.

Indications for the Procedure: This is a female who came in today for the above noted procedure. The risks and complications were reviewed with the patient preoperatively; these included but not limited to infection, bleeding, scars, postoperative asymmetries, and need for touchup. The patient also requests a lip lift. The patient is aware of the risks of scars.

Description of the Procedure: She was brought to the Operating Room where she was injected with 15cc of 50:50 mixture of 1% Xylocaine with adrenaline and 15 Xylocaine with adrenaline mixed with Wydase. After adequate anesthesia was achieved, the patient underwent a right hemitransfixion and bilateral intracartilaginous incisions. The dorsal septum inferior to the nasal bones were elevated. The patient was noted to have old scar tissue, which was resected. No extra cartilage noted. The patient's wounds were closed using #4-0 chrome sutures. Approximately 3mm of lip of the nasal vestibule traversing the inferior columella was resected. The wounds were closed using #5-0 Vicryl suture and a running #5-0 Prolene suture. Mastisol and Steri-Strips were applied to the dorsum.

Plan: She was discharged to home on oral antibiotics and pain meds to office follow-up.

[Dr. Cohen's signature]
Barry J. Cohen, M.D., F.A.C.S., P.C.
Diplomate, American Board of Plastic Surgery
Dictated but not read

BJC/kt D: 11/08/06 T: 11/11/06

From November 14, 2006, to December 29, 2009, Patient 6 returned to Dr. Cohen's office 21 times to see either Dr. Cohen or a physician assistant in the office. The purposes of these visits were to follow-up on procedures, to revise procedures, to address an infection, to remove a cyst, or for a Kenalog 10 or other injection. Photographs of the patient were taken during several of these visits. These visits are recorded in brief handwritten office notes by Dr. Cohen or a physician assistant or by a dictation by a physician assistant (later transcribed).

CONCLUSIONS OF LAW

The Board concludes that, in regard to Patients 2, 4, and 6, Dr. Cohen failed to keep adequate medical records as determined by appropriate peer review, in violation of section 14-404(a)(40) of the Health Occupations Article.

ORDER

On an affirmative vote of a majority of a quorum of the Board, it is hereby

ORDERED by the Board that Barry J. Cohen, M.D. is **REPRIMANDED;** and it is further

ORDERED by the Board that Dr. Cohen will be subject to a chart review in six months by the Board, its agents, or designees; and it is further

ORDERED that this Final Decision and Order is a public document.

3-25-13
Date

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

NOTICE OF APPEAL RIGHTS

Pursuant to section 14-408(b) of the Health Occupations Article, Dr. Cohen has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review must be filed within 30 days from the date this Final Decision and Order is mailed. The date of the cover letter to this Final Decision and Order indicates the date that this Final Decision and Order was mailed. The petition for judicial review must be made as directed in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222, and Maryland Rules 7-201 *et seq.*

If Dr. Cohen petitions for judicial review, the Board is a party and should be served with the court's process. In addition, Dr. Cohen should send a copy of his petition for judicial review to the Board's counsel, David Wagner, Assistant Attorney General, Office of the Attorney General, 300 W. Preston Street, Suite 302, Baltimore, Maryland 21201. The administrative prosecutors are not involved in the circuit court process and do not need to be served or copied on pleadings filed in circuit court.