

IN THE MATTER OF
BARRY I. ARON, M.D.

Respondent

License Number: D46143

* * * * *

* BEFORE THE MARYLAND
* BOARD OF PHYSICIANS
* Case Numbers: 2006-0886
2007-0582

CONSENT ORDER

On April 23, 2008, , the Maryland Board of Physicians (the "Board") charged Barry I. Aron, M.D. (the "Respondent") (D.O.B. 7/6/63), License Number D46143, with violating the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2005 Repl. Vol. & 2007 Supp.).

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

§ 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:

- (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[.]

GENERAL FINDINGS OF FACT

1. At all times relevant hereto, the Respondent, who is board-certified in obstetrics and gynecology, was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on June 7, 1994.

2. At all times relevant hereto, the Respondent maintained an office for the practice of obstetrics and gynecology at 505 Washington Avenue in LaPlata, Maryland and held privileges at Civista Medical Center and Southern Maryland Hospital Center.
3. In July 2006 and January 2007, the Board received complaints from 2 of the Respondent's patients regarding his care of them.
4. The Board initiated an investigation of this matter. Pursuant to its investigation, the Board referred the matter to Permedion, a Peer Review organization, for review of the Respondent's practice.
5. The peer reviewers opined that the Respondent failed to meet appropriate standards for the delivery of quality medical care for reasons that are set forth below.

IV. Patient-Specific Findings of Fact

Patient A

6. Patient A, a female born in 1980, initially presented to the Respondent for pre-natal care on December 2, 2004. Her estimated date of confinement was July 18, 2005. Patient A's prenatal course was relatively uneventful.
7. On the evening of July 11, 2005, Patient A was admitted to the hospital for induced labor; she had had a prolonged latent phase with contractions every 4 to 5 minutes off and on for the previous 5 days. At the time of her admission, her cervix was 1 cm dilated and soft.
8. On the evening of July 11, 2005, the Respondent ordered Cervidil, a vaginal insert used to start or continue cervical ripening, to be placed.

9. On the morning of July 12, 2005, the Respondent ordered Pitocin to be administered. Pitocin was continued the entire day to encourage her progression into active labor; however, Patient A's cervix remained only 1 cm dilated and 50% effaced by the evening of July 12.¹
10. On the evening of July 12, the Respondent ordered a second Cervidil be placed. Patient A's cervix had dilated to 2 cm by the morning of July 13 and she progressed very slowly over the next 24 hours.
11. On July 14, 2005 at 7:20 a.m., the Respondent documented that Patient A was completely effaced, her cervix was a rim and the fetal head was at +1 station.²
12. Approximately 4 hours later, at 11:45 a.m., the Respondent noted that Patient A's cervix was unchanged but, "vertex appears to come through cervix with [contractions]." The Respondent further noted that Patient A was having contractions every 2 to 3 minutes and that the fetal heart rate was in the 150 – 160's. The Respondent further noted, "will try pushing & see if cervix reduces."
13. At approximately 3:10 p.m. on July 14, 2005, the Respondent noted that Patient A had pushed for 3 hours with arrest of descent at +2 station. According to the nursing notes, the Respondent spoke to Patient A and

¹ Progress in labor is assessed in part by cervical effacement, which is the thinning or stretching of the cervix, and the dilation, or opening, of the cervix as it prepares for fetal passage through the vaginal opening.

² The term "station" denotes the degree of engagement of the fetal head as it navigates the maternal pelvis. It describes the level of the presenting fetal part in relationship to the ischial spines of the maternal pelvis. Positive values, from +1 to +5, denote descent below the ischial spines; +5 station indicates corresponds to the fetal head being visible at the vaginal opening. When deposed, the Respondent testified that he uses the "old scale" that divides the fetal descent into thirds; zero station denotes that the fetal head is at the ischial spines and +3 denotes the crowning of the fetal head.

her husband about assisting Patient A's delivery with forceps with subsequent Cesarean delivery if the forceps delivery was unsuccessful.

14. At or about 3:23 p.m., the Respondent applied forceps while Patient A was pushing with contractions. At or about 3:26 p.m., the Respondent stopped applying the forceps.
15. In his operative note, the Respondent documented that during the forceps delivery, he was unable to "get descent beyond +3 station ...with return of the vertex to +2 after the forceps were removed."
16. The Respondent also noted "persistent fetal bradychardia;"³ the nursing notes indicate that after the forceps attempt, the fetal heart rate had decreased to the 60's (fetal heart beats per minute).
17. On July 14, 2005 at or about 3:30 p.m., the Respondent again attempted a forceps delivery, documenting in his operative note that the second attempt was made "to effect the fastest delivery." The nursing note indicates that after the Respondent's second forceps attempt, the fetal heart rate decreased to the 50's with no variability. The Respondent's second attempt to deliver the infant with forceps was not successful.
18. At or about 3:39 p.m., Patient A was taken to the operating room for an emergency Cesarean delivery.
19. At or about 3:44 p.m., the Respondent delivered of Patient A a full-term 9 pound male infant with no heartbeat and whose Apgar scores at 1 minute

³ The normal fetal heart rate ("FHR") is between 120 and 160 beats per minute. Fetal bradychardia is defined as a baseline heart rate less than 120 beats per minute.

and 5 minutes were 0. Resuscitative efforts failed and the infant expired on July 14, 2005 at approximately 6:20 p.m.

20. On the Authorization for Autopsy, the Respondent documented "placental abruption"⁴ as his clinical impression as to cause of death.
21. The autopsy report noted an acute hemorrhage on the infant's subcutaneous scalp and a subgaleal acute hemorrhage. The report's Summary of Findings states in pertinent part: "The subgaleal and focal dural acute hemorrhage is consistent with a history of attempted forceps delivery."
22. The autopsy report also noted that the infant was large, weighing 4100 grams.
23. The Respondent's conduct as set forth above, in whole or in part, constitutes the violation of the standard of quality care for reasons including but not limited to the following:
 - a. The Respondent instructed Patient A to start pushing even though she was not completely dilated;
 - b. Patient A had undergone a protracted second stage of labor with the arrest of descent of a large fetus; the standard of quality care required that she be delivered by a Cesarean delivery, rather than by forceps;
 - c. The Respondent made 2 forceps delivery attempts even after fetal distress had occurred after the first attempt. In

⁴ Placental abruption is complication of pregnancy wherein the placental lining has separated from the uterus of the mother.

this situation, the standard of quality care required that the Respondent immediately abandon the use of forceps after his first attempt had failed and emergently deliver by Cesarean section.

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 for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22).

ORDER

Based on foregoing Findings of Fact and Conclusions of Law, it is this 25th day of June, 2009, by a majority of the quorum of the Board considering this case:

ORDERED that the Respondent's license to practice medicine in the State of Maryland shall be reprimanded; and it is further

ORDERED that the Respondent shall be placed on probation subject to the following conditions:

- (1) Within three (3) months of the date of the Consent Order, the Respondent shall successfully take a Board-approved intensive course in high-risk obstetrics, which shall include post-delivery complications. If the Respondent is not able to find a high-risk obstetrics course that includes post-delivery

complications, he must take two (2) courses, one (1) with each of these subjects;

- (2) A peer review or chart review of the Respondent's practice shall take place within six (6) months of the date of the Consent Order; and
- (3) If the Respondent complies with the terms of this Consent Order, he may apply for termination of probation upon the completion of the peer or chart review, provided that the peer or chart review is satisfactory to the Board; and it is further

ORDERED that the Respondent shall comply with the Maryland Medical Practice Act and all laws, statutes and regulations pertaining to the practice of medicine; and it is further

ORDERED that the Respondent's failure to comply with any of the conditions of this Consent Order, shall be considered a violation of probation and a violation of this Consent Order; and it further

ORDERED that if the Respondent violates any of the terms and conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, or an opportunity for a show cause hearing before the Board, may impose any other disciplinary sanction for with the Board may have imposed, including a

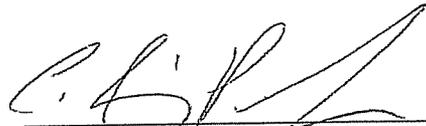
reprimand, probation, suspension, revocation and/or monetary fine, said violation being proven by a preponderance of the evidence; and it is further

ORDERED that the Respondent shall not petition the Board for early termination of the terms and conditions of this Consent Order; and it is further

ORDERED that the Respondent shall be responsible for all costs under this Consent Order; and it is further

ORDERED that this Consent Order shall be a public document pursuant to Md. State Gov't Code Ann. § 10-611 (2004 Repl. Vol.).

6/25/09
Date


C. Irving Pinder, Jr.
Executive Director
Maryland Board of Physicians

CONSENT

I, Barry I. Aron, M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering 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 the

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 I 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.

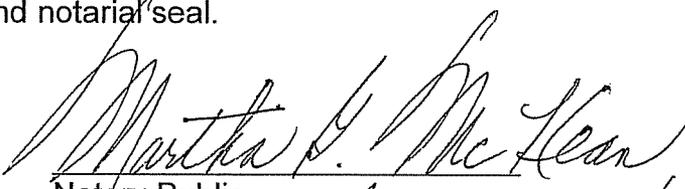
6/5/09
Date


Barry I. Aron, M.D.
Respondent

STATE OF MARYLAND
CITY/COUNTY OF Charles

I HEREBY CERTIFY that on this 5th day of June 2009, before me, a Notary Public of the foregoing State and City/County personally appeared Barry I. Aron, M.D., 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.


Notary Public
My Comm. Expires: 11/1/09