

IN THE MATTER OF

BARRY J. WALDMAN, M.D.

Respondent

License Number: D53580

*

*

*

*

BEFORE THE

MARYLAND BOARD OF

PHYSICIANS

Case Number: 2006-0159

*

*

*

*

*

*

*

*

*

*

*

*

CONSENT ORDER

On or about June 1, 2009, the Maryland Board of Physicians (the "Board") charged Barry J. Waldman, M.D. (the "Respondent") (D.O.B. 3-15-66), License Number D53580, with violations under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2000 & 2005 Repl. Vols.)

The pertinent provision of the Act under H.O. § 14-404 provides the following:

(a) 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.

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

A Case Resolution Conference was held on October 7, 2009, at the Maryland Board of Physicians, and was attended by: The Respondent and his attorney David McManus, Esquire, and the Administrative Prosecutor, Assistant Attorney General,

Debra A. Smith. Following the Case Resolution Conference, the parties and the Board agreed to the following:

FINDINGS OF FACT

The Board makes the following findings of fact:

Background

1. At all times relevant to these charges, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on June 23, 1998, and was issued License Number D53580.

2. The Respondent is board-certified in Orthopedics and maintains an office for the practice of medicine at the following location: OrthoMd, 2700 Quarry Lake Drive, Suite 300, Baltimore, Maryland 21209.

3. The Board initiated an investigation of the Respondent after receiving a report in or about October 2004, that the Respondent had diagnosed a patient with left knee osteonecrosis,¹ and performed a total knee replacement without waiting to review Magnetic Resonance Imaging ("MRI")² results, which revealed that the patient had cancer in the left knee.

4. The Board requested a practice review of four patient records. The reviewers determined that the Respondent failed to meet the standard of care for the

¹ Osteonecrosis is the death of a segment of bone caused by an impaired blood supply. This impairment can be caused by a non-traumatic injury or a traumatic injury such as a previous fracture. The symptoms include pain and swelling and limitation of motion in the joint.

² Magnetic Resonance Imaging (MRI) is primarily a medical imaging technique most commonly used in radiology to visualize the internal structure and function of the body.

delivery of quality medical and surgical care in two of the four cases reviewed, including the case of the patient who was diagnosed with knee cancer.

Patient Specific Facts

Patient A

5. In or about November of 2000, the Respondent examined a male patient, hereinafter "Patient A,"³ for complaints of left knee pain. The office notes indicate that radiographic findings "show a large osteonecrotic lesion filling almost the entire lateral and medial femoral condyle."⁴ The Respondent diagnosed osteonecrosis and recommended total knee arthroplasty ("TKA").⁵ The MRI results were suggestive of a tumor, and additional MRI evaluation was recommended. The Respondent did not order additional MRI imaging. Instead, the Respondent ordered a CT scan,⁶ which was performed on November 16, 2000.

6. On November 20, 2000, the Respondent operated on Patient A, and performed a total left knee replacement. The Respondent reports that prior to the surgery he was verbally informed by the radiologist that the CT scan was negative for cancer. An intraoperative frozen section was read as focus suggestive of nodular tenosynovitis.⁷ The final pathology report, however, indicated cancer. The CT scan was interpreted on November 29, 2000, and revealed cancer. Subsequently, Patient

³ For confidentiality purposes the identity of the patient is not included in this document. The Respondent may obtain the identity of all individuals referenced in this document by contacting the administrative prosecutor.

⁴ The lateral and medial femoral condyle are the two knobs at the bottom of the thigh bone that sit on the meniscus and tibial plateau of the knee.

⁵ Total Knee Arthroplasty (TKA) is total knee replacement surgery.

⁶ Computed Tomography (CT) is a medical imaging technique employing tomography, which is often used for diagnostic purposes to get images of body structures and function.

⁷ Nodular tenosynovitis is a benign tumor that grows in and around the soft tissue surrounding a joint. This growth is usually seen in the hands, but can occur in the knee.

A's leg was amputated and he began chemotherapy. The patient died of cancer in 2003.

7. The Respondent failed to meet the standard of care because he failed to initiate appropriate follow-up after receiving an MRI report that was suggestive of a tumor and recommended follow-up imaging. The Respondent failed to order additional MRI imaging as recommended. The Respondent failed to order a biopsy to determine whether there was a malignancy in the left knee prior to proceeding to surgery. The Respondent ordered a CT scan performed, but performed the surgery prior to receiving the results interpreting the CT scan.

Patient B

8. The patient, a former professional athlete, hereinafter "Patient B," was referred to the Respondent by another physician who was treating him, hereinafter "Physician A." Patient B had a long history of knee problems. He underwent a right total knee arthroplasty (TKA) in October 1986 and a revision right TKA in March 1997. Patient B saw Physician A in July of 1997 for complaints of swelling in the right knee. He was obese and had a history of Type Two diabetes. The medical records indicate that in December 1997, Patient B had a right knee infection and was treated with antibiotics. He was treated for recurrent tibial abscesses in December 1997.

9. On or about April 22, 1999, Physician A referred Patient B to the Respondent for a consultation. The Respondent reviewed the patient's radiographs, and noted an infected, loose right long stem, semi-constrained, total knee replacement. The Respondent recommended that Physician A remove the components, place a cement spacer and wait at least two months until the infection had cleared up and then

proceed with fusion bone grafting.⁸ On or about May 13, 1999, Physician A performed a revision surgery on the right knee with placement of antibiotic spacers.

10. The Respondent recommended that Patient B have a fusion bone grafting. Instead, Patient B insisted on having revision TKA. The patient was advised of the risk associated with TKA, but decided to proceed with the surgery. On or about November 23, 1999, the Respondent performed TKA revision surgery on Patient B. The Respondent treated patient B postoperatively with Coumadin⁹ for two days, and then prescribed Ecotrin¹⁰ prior to his discharge from the hospital.

11. In Treatment notes the Respondent reported that Patient B was doing well at a follow-up visit on or about December 1, 1999. On or about December 11, 1999, Patient B was admitted to the hospital for shortness of breath. A V/Q scan¹¹ indicated a high probability of pulmonary embolism,¹² and Patient B was treated with Heparin and Coumadin. Patient B was taken off the Heparin¹³ and Coumadin and placed on Lovenox¹⁴ after it was determined that he needed immediate knee surgery.

⁸ Fusion bone grafting (Arthrodesis) is a procedure, where the surgeon cuts the ends of the femur and tibia bones then presses the flat ends together. Pins, plates, or screws hold the bones together, and over the next couple of months the bones grow together. Knee fusion is usually performed when a total knee replacement fails.

⁹ Coumadin is an anticoagulant (blood thinner), which reduces the formation of blood clots. It is used to prevent heart attacks, strokes, and blood clots in veins and arteries.

¹⁰ Ecotrin is an aspirin, which is administered to prevent the formation of blood clots.

¹¹ A pulmonary ventilation/perfusion scan refers to two separate nuclear scan tests that use inhaled and injected radioactive materials (radioisotopes) to measure breathing (ventilation) and circulation (perfusion) in all areas of the lung. These tests are generally used to detect pulmonary embolus.

¹² A pulmonary embolism (PE) is a blockage of the pulmonary artery or one of its branches, usually occurring when a blood clot from a vein becomes dislodged from its site of formation and travels to the arterial blood supply of one of the lungs. PE is a dangerous condition which can lead to death.

¹³ Heparin is a naturally occurring anticoagulant, which prevents the formation of clots and extensions of clots within the blood.

¹⁴ Lovenox is an anticoagulant generally prescribed to prevent the formation of blood clots.

12. On or about December 14, 1999, the Respondent operated on Patient B for a severe knee infection. Patient B went into cardiac arrest during the surgery and died later of a pulmonary embolism.

13. The Respondent failed to meet the standard of care because he failed to provide documentation in the medical records documenting the basis for discontinuing the Coumadin. At the December 1, 1999, follow-up visit the Respondent failed to perform testing to determine the efficacy of the Ecotrin for anticoagulation therapy even though Patient B was in a high risk category for developing blood clots. The Respondent also failed to consider prophylactic placement of a Greenfield filter¹⁵ as protection against Patient B's development of a pulmonary embolism.

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 standard of care when providing care to Patient's A and B in violation of H.O. § 14-404(a)(22). The Respondent also failed to maintain adequate medical records for Patient's A and B, a violation of H.O. § 14-404(a)(40).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 16TH day of December, 2009, by a majority of the quorum of the Board considering this case hereby:

¹⁵ A Greenfield filter is an Inferior Vena Cava ("IVC") filter, a medical device that is implanted in the inferior vena cava, the large vein that carries deoxygenated blood from the lower half of the body into the right atrium of the heart, for prophylactic use in patients with a high risk of pulmonary embolism.

ORDERED that effective the date of this Consent Order, 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** for a minimum of one (1) year and until all of the following terms and conditions are successfully completed:

ORDERED that the Respondent shall be subject to the following conditions:

- (a) Within twelve (12) months of the date of this Order, the Respondent shall enroll in, and complete a Board-approved course in medical record keeping. The Respondent is responsible for the cost of the course and all expenses associated with the course. This course may not count toward fulfilling the continuing education requirements the Respondent must fulfill in order to renew his license to practice medicine;
- (b) The Respondent will be subject to a peer review or chart review, by an appropriate peer reviewer to be determined at the discretion of the Board.
- (c) The peer review or chart review will be a random review of patient records, selected in accordance with paragraph (b) above. In order to comply with this condition the Respondent's documentation and standard of quality care must be approved by the peer reviewer.

ORDERED, that the Respondent shall be responsible for all costs associated with fulfilling the terms and conditions of this Consent Order; and be it further

ORDERED that any violation of the terms/and or conditions of the Consent Order, including an unacceptable peer review or chart review as described above, shall be deemed a violation of this Consent Order; and be 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 which the Board may have imposed in this case under §§ 14-404(a) and 14-405.1 of the Medical Practice Act, including a reprimand, probation, suspension, revocation and/or a monetary fine, said violation being proven by a preponderance of the evidence; and be it 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 be it further

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

16 December 2009
Date

Paul T. Elder, M.D.
Paul T. Elder, M.D., Chair
Maryland Board of Physicians

CONSENT

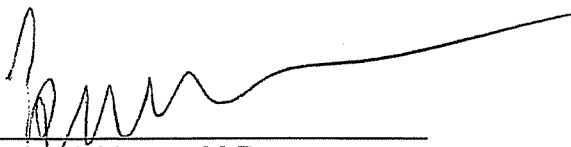
I, Barry J. Waldman, M.D., License No. D53580, by affixing my signature hereto, acknowledge that:

1. I have consulted with counsel, David McManus, Esquire, and knowingly and voluntarily elected to enter 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.

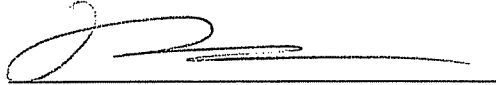
2. I am aware that I am entitled to a formal evidentiary hearing, pursuant to Md. Health Occ. Code Ann. § 14-405 (2009 Repl. Vol.) and Md. State Gov't Code Ann §§ 10-201 *et seq.* (2009 Repl. Vol.).
3. I acknowledge the validity and enforceability of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have 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 am waiving those procedural and substantive protections.
4. I voluntarily enter into and agree to abide by the terms and conditions set forth herein as a resolution of the Charges against me. I waive any right to contest the Findings of Fact and Conclusions of Law and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this Consent Order or any adverse ruling of the Board that might have followed any such hearing.
5. I acknowledge that by failing to abide by the conditions set forth in this Consent Order, I may be subject to disciplinary actions, which may include revocation of my license to practice medicine.
6. I sign this Consent Order voluntarily, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

November 11, 2009
Date



Barry J. Waldman, M.D.
Respondent

11-16-09
Date



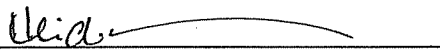
David McManus, Esquire

NOTARY

STATE OF Maryland
COUNTY OF St. Mary's :

I HEREBY CERTIFY that on this 11th day of November, 2009 before me,
a Notary Public of the State and County aforesaid, personally appeared Barry J.
Waldman, M.D., License Number D53580, and gave oath in due form of law that the
foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal:



Notary Public

My commission expires: September 1, 2010