IN THE MATTER OF	*	**BEFORE THE**
ADAM N. SUMMERS, M.D.	*	**MARYLAND BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D55340	*	**Case Number: 2004-0603**

* * * * * * * * * * * *

CONSENT ORDER

On July 13, 2007, the Maryland Board of Physicians (the "Board") charged Adam N. Summers, M.D. (the "Respondent") (D.O.B. 03/05/67), License Number D55340, with violating the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2000 and 2004 Supp.).

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

> 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[.]

On September 5, 2007, a conference with regard to this matter was held before the Case Resolution Conference ("CRC"). As a result of negotiations entered into after the CRC, the Respondent agreed to enter into this Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. At all times relevant hereto, the Respondent, who is board-certified in plastic surgery, was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on October 1, 1999. The Respondent holds an inactive medical license in Wisconsin.

2. The Respondent maintains an office for the practice of plastic surgery, Maryland Plastic Surgery Associates, located at 7704 Quarterfield Road, Glen Burnie, Maryland. At all times relevant hereto, the Respondent had medical staff privileges at Anne Arundel Medical Center and Howard County General Hospital.

PROCEDURAL HISTORY

3. On March 4, 2004, the Board received a complaint from a former employee of the Respondent that articulated several concerns regarding the Respondent's practice. The complainant, in part, alleged that the Respondent, when conducting a breast augmentation procedure, filled the patient's implants with lactated ringer's solution rather than the saline solution that was required by the implant manufacturer.

4. In furtherance of its investigation of this aspect of the complaint, Board staff obtained the name of the breast implant patient (hereinafter "Patient A"[1]) referred to in the complaint.

5. On November 24, 2004, Board staff interviewed Patient A, who thereafter filed a written complaint regarding the Respondent in which she alleged,

[1] The name of the patient is confidential.

inter alia, that the Respondent filled her breast implants with lactated ringer's solution rather than saline and failed to inform her until several months after the procedure.

PATIENT-SPECIFIC FINDINGS OF FACT

6. On August 25, 2003 and September 15, 2003, Patient A, a registered nurse who was then forty (40) years old, consulted with the Respondent regarding possible breast augmentation. The Respondent explained the procedure to Patient A, including the risks and took "before" photographs.

7. On December 15, 2003, Patient A advised the Respondent that, in addition to breast augmentation, she also wanted a breast lift ("mastopexy").

8. During the consultations, the Respondent had informed Patient A that 99% of his practice consists of breast augmentation procedures. He also informed Patient A that he does not like silicone to fill breast implants and uses saline solution in most procedures.

9. On January 15, 2004, the Respondent performed a bilateral submuscular augmentation and inverted "T" mastopexy on Patient A.

10. On January 15, 2004, prior to her surgical procedure, Patient A signed an informed consent form entitled, "Maryland Plastic Surgery Informed Consent for Saline Breast Implant and Breast Lift." The Informed Consent form consists of several paragraphs, all of which were initialed by Patient A to indicate that she had read and understood the various statements of risks contained therein. The first paragraph on the Informed Consent form

states in pertinent part: "I desire to have breast enhancement surgery with *saline filled* breast implants by Dr. Adam Summers." (Emphasis added).

11. The Respondent documented Patient A's surgical procedure in a January 15, 2004 operative note. In his operative note, the Respondent documented that he had prepared the implants by removing all residual air and filling the implant with "50 cc of sterile saline using a closed system." The Respondent further documented that, "[t]he implant was filled to the manufacturer's recommended fill size. The same procedure was performed on the opposite breast."

12. Following the surgical procedure, the Respondent provided to Patient A a "Device Identity Card" that indicated that her breast implants were filled with saline, and specifying that "400cc" had been used to fill the right breast implant and "380 cc" had been used to fill the left implant.

13. Approximately one (1) week after the surgery, the incision under Patient A's left breast opened and required follow-up care by the Respondent on February 5, 2004, February 16, 2004, February 25, 2004, March 15, 2004 and April 14, 2004. The Respondent treated Patient A at each of the visits. At no time during these visits did he inform Patient A that he had filled her implants with lactated ringer's solution rather than saline.

14. On May 28, 2004, Patient A presented for her six (6) month follow-up appointment. The Respondent examined her and discharged her from his care. The Respondent did not inform Patient A during this visit that he had filled her implants with lactated ringer's solution rather than saline.

15. On August 17, 2004, Board staff interviewed the Respondent regarding the complaint his former staff member had submitted, including the allegation pertaining to Patient A. Initially, the Respondent denied having any concern regarding Patient A's procedure. Board staff then requested the Respondent to review his treatment record for Patient A. The Respondent then recalled that he had filled a patient's implants with lactated ringer's solution, but had forgotten that the patient had been Patient A.

16. With regard to Patient A's surgical procedure, the Respondent informed Board staff that after Patient A was placed under general anesthesia and he had begun his incisions, he discovered that his office had no sterile saline in stock.

17. The Respondent stated that, rather than closing the patient without completing the procedure, he substituted lactated ringer's solution for the saline solution.

18. The Respondent acknowledged that he had not noted on the implant identification stickers that the warranty on the implants was voided as a result of his substitution.

19. The Respondent further acknowledged that he had not informed Patient A of the substitution because he believed it posed no additional risk to her.

20. The Respondent told Board staff that he had an upcoming appointment with Patient A and would notify her of the substitution at that time.

21. In late August, 2004, the Respondent saw Patient A at a neighborhood pool. He told her that he was having staffing problems and discussed the possibility of hiring Patient A to work in his office.

22. According to Patient A, the Respondent left several voice mail messages on her telephone during September 2004 asking her to call his office to schedule a follow-up on her implants. The Respondent did not provide additional information in the messages regarding why he wanted her to come in for a follow-up.

23. On September 27, 2004, the Respondent sent to Patient A an e-mail message in which he stated that he wanted to talk to her about an available nursing position in his office and that he would like her "to come in for a follow-up."

24. In mid-October 2004, Patient A met with the Respondent in an examining room in his office prior to regular office hours. In response to Patient A's inquiry whether there was a problem with her implants, the Respondent responded, "Kind of."

25. The Respondent explained that the nurse who was working in the operatory on the day of Patient A's procedure had not checked to make sure that saline was available for Patient A's implants.

26. The Respondent further explained to Patient A that since she was already under general anesthesia and opened up and his next case was waiting, he had filled Patient A's implants with lactated ringer's solution, which was in stock.

27. The Respondent blamed the failure to have saline in stock on the nurse and did not apologize to Patient A. He told Patient A that he was going to tell her about the substitution at earlier appointments but had forgotten.

28. The Respondent attempted to appeal to Patient A's medical background, noting that lactated ringer's solution is isotonic as is saline, so theoretically, there should be no adverse effect on her implants.

29. The Respondent admitted to Patient A that the implant warranty was void because he had failed to fill them according to the manufacturer's specifications.

30. The Respondent offered to take care of any problems Patient A might have with the implants for free and suggested three options: 1) do nothing because the implants are fine; 2) remove the lactated ringer's solution and replace it with saline; or 3) replace the entire implant.

31. Patient A initially felt she had no recourse but to replace the implants and so informed the Respondent, who encouraged her to have the procedure soon.

32. Patient A subsequently changed her mind and had a different plastic surgeon ("Surgeon B") replace the implants at her own expense.

33. Surgeon B's records reflect that on February 27, 2005, Surgeon B contacted the Respondent by telephone and requested Patient A's records. On March 3, 2005, Surgeon B received from the Respondent only the notes of Patient A's pre-operative consultations, thus

necessitating an additional request to the Respondent for Patient A's entire medical record.

34. Review of the Respondent's operative note that he subsequently transmitted to Surgeon B reveals that the Respondent had originally documented in the typed note that he had filled the implant with "50 cc of sterile saline using a closed system." When the operative note was received by Surgeon B, the word "saline" had been crossed out and the notation "LR" had been written by hand over the crossed-out word. In the left margin of the note, the initials "AS" and the date "08/17/04" had been hand written.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's actions constitute unprofessional conduct in the practice of medicine, in violation of H.O. § 14-404(a)(3)(ii).

ORDER

Based on foregoing Findings of Fact and Conclusions of Law, it is this 24th day of October, 2007, 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** for a minimum of **TWO (2) YEARS**, beginning on the effective date of the Consent

Order and continuing **UNTIL** all of the following terms and conditions are satisfied:

a. No later than six (6) months from the effective date of the Consent Order, the Respondent shall successfully complete a prior Board-approved intensive ethics course/tutorial. The Respondent shall submit the written course description/syllabus to the Board prior to enrolling in the course, for the Board's approval. The Board reserves the right to require the Respondent to provide further information regarding the course he proposes, and further reserves the right to reject the proposed course and require submission of an alternative proposed course. The Board will approve the proposed course only if it deems the curriculum and the duration of the courses adequate to fulfill the need. The Respondent shall be responsible for all costs incurred in fulfilling this course requirement and shall be responsible for submitting written documentation to the Board showing that he has successfully completed the course. This course requirement shall not apply toward, and shall be in addition to, the Continuing Medical Education requirements for continued medical licensure in the State of Maryland. The Respondent shall not apply any previous course he has already taken and completed as fulfillment of this course requirement;

b. No later than six (6) months from the effective date of the Consent Order, the Respondent shall pay a monetary fine in the amount of twenty thousand dollars ($20,000.00), by certified or bank guaranteed check made payable to the Maryland State Board of Physicians; and

c. Within six (6) months of the effective date of the Consent Order, the Respondent shall undergo a chart and/or peer review focused on Respondent's compliance with the applicable standard of care and the timeliness of Respondent's completion of operative reports; and it is further

ORDERED that the Respondent's failure to comply with any of the conditions of the Consent Order shall be deemed a violation of Probation and a violation of the Consent Order for which the Board may impose additional sanctions; and it is 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 a hearing, may impose any other disciplinary sanctions it deems appropriate, including but not limited to a reprimand, probation, suspension, revocation and/or a monetary fine; 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 shall be a **PUBLIC** DOCUMENT pursuant to Md. State Gov't. Code Ann. § 10-611 *et seq.* (2004).

10/29/07
Date

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

CONSENT

I, Adam N. Summers, 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.

10/13/07
Date

Adam N. Summers, M.D.
Respondent

STATE OF MARYLAND
CITY/COUNTY OF Anne Arundel

I HEREBY CERTIFY that on this 13th day of October 2007, before me, a Notary Public of the foregoing State and City/County personally appeared Adam N. Summers, M.D., License Number D55340, 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

ex 1/21/08