IN THE MATTER OF	*	**BEFORE THE**
DAVID V. MARTINI, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D59096	*	**Case Number: 2011-0499**

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

CONSENT ORDER

On December 18, 2012, the Maryland State Board of Physicians (the "Board") charged **DAVID V. MARTINI, M.D.** (the "Respondent"), License Number D59096, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2009 Repl. Vol.).

Specifically, the Board charged the Respondent with violating the following provisions of the Act under Health Occ. § 14-404:

> (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 the State; [and]
>
> (41) Performs a cosmetic surgical procedure in an office or a facility that is not:
>
> (i) Accredited by:
>
> 1. The American Association for Accreditation of Ambulatory Surgical Facilities;
>
> 2. The Accreditation Association for Ambulatory Health Care; or

3. The Joint Commission on the Accreditation of Health Care Organizations; or

(ii) Certified to participate in the Medicare program, as enacted by Title XVIII of the Social Security Act.

On July 3, 2013, a settlement conference was held before the Board's Disciplinary Committee for Case Resolution. As a resolution of the case, the Respondent agreed to enter into this public Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

BACKGROUND

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed in Maryland on June 25, 2002, under License Number D59096. The Respondent's license is active until September 30, 2013.

2. The Respondent is board-certified in otolaryngology and has a subspecialty certification in plastic surgery within the head and neck.

3. At all times relevant hereto, the Respondent maintained a medical office, Replenish Cosmetic Institute, at 330 East Pulaski Highway, Elkton, Maryland 21921.

COMPLAINT

4. The Board initiated an investigation of the Respondent after receiving an anonymous complaint, on or about January 12, 2011, alleging that on or about December 15, 2010, the Respondent performed back and abdominal liposuctions on an

adult female patient ("Patient A"),[1] who went into cardiac arrest during the procedure and died seven days later. The complainant expressed concerns that the Respondent was performing liposuctions, even though he was not trained in plastic surgical procedures of the body, utilized only a certified registered nurse anesthetist during the procedures, and performed liposuctions in his office, which was not a certified surgical facility.

BOARD INVESTIGATION

5. As part of its investigation, the Board subpoenaed the Respondent for "a complete list of documents acknowledging that the practice known as Replenish Cosmetic Institute located at #330 East Pulaski Highway in Elkton Maryland is a certified operating facility..."

6. By letter dated October 19, 2011, to the Board, the Respondent wrote, "IN ANSWER TO SUBPOENA QUESTION: I DO NOT REPRESENT REPLENISH TO BE A CERTIFIED OPERATING FACILITY."

7. On or about December 7, 2011, the Board submitted Patient A's medical records and related Board investigative materials to an appropriate entity for peer review. The findings of the peer review are set forth *infra*.

8. Patient A, then in her early thirties, initially saw the Respondent in October 2010 for consultation regarding excess back and abdominal fat and underarm hair removal. Patient A had a history of breast reduction in October 1999 and abdominal liposuction and buttock fat augmentation in April 2010. The Respondent assessed

[1] To ensure confidentiality, the names of individuals, hospitals and healthcare facilities involved in this case, other than the Respondent, are not disclosed in this document.

Patient A with having moderate excess fat in her upper abdomen, the bra bulge, back, hips, waist and flanks, and scheduled her for a multi-site laser liposuction.

9. The Respondent retained an outside contractor (the "Contractor") to provide anesthesia services to Patient A during the scheduled laser liposuction. According to Patient A's medical record, a nurse from the Respondent's office scheduled with the Contractor and advised the Contractor that the surgical procedure would require approximately seven hours, give or take one hour.

10. Following pre-operative consultations and medical clearance, Patient A underwent laser liposuction at the Respondent's office on or about the morning of December 15, 2010.

11. Prior to the surgery, on December 15, 2010, a certified registered nurse anesthetist (the "CRNA"), sent by the Contractor, met with Patient A at the Respondent's office and obtained her consent for administration of intravenous ("IV") sedation.

12. At approximately 8:14 a.m., the CRNA initiated IV sedation, which included Versed 5 mg, fentanyl 300 mcg and propofol 300 mg. The Respondent began surgery at approximately 8:30 a.m. By 10:35 a.m., the Respondent had completed the abdominal portion of the liposuction. The CRNA noted that he discontinued the IV because Patient A was "moving and blocking." The CRNA then restarted the IV in Patient A's right hand.

13. Patient A was turned to her right side at approximately 10:40 a.m., and her oxygen saturation was at 98%. At approximately 10:42 a.m., the CRNA noted that Patient A had poor EKG and oxygen saturation readings. He assessed Patient A and

found no breath sound. The CRNA inserted an oral airway and by 10:43 a.m. initiated cardiopulmonary resuscitation. At approximately 10:51 a.m., emergency medical services arrived and assumed care of Patient A.

14. Patient A died at a hospital one week later, on December 22, 2010. Her death certificate listed the causes of death as anoxic brain injury, cardiac arrest, and cardiomyopathy and surgical procedure with anesthesia.

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 and surgical care when he failed to supervise the CRNA properly, in violation of Health Occ. § 14-404(a)(22). Additionally, the Respondent violated Health Occ. § 14-404(a)(41), when he Performed a cosmetic surgical procedure, *i.e.* laser liposuction, on Patient A at his office, which is neither a facility accredited by the American Association for Accreditation of Ambulatory Surgical Facilities; the Accreditation Association for Ambulatory Health Care; or the Joint Commission on the Accreditation of Health Care Organizations, nor a facility certified to participate in the Medicare program, as enacted by Title XVIII of the Social Security Act.

ORDER

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

ORDERED that the Respondent is hereby **REPRIMANDED**; and it is further

ORDERED that **within ten (10) days** of the execution of the Consent Order, the Respondent shall pay a fine of five thousand dollars ($5,000) by money order or

certified check to the Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297; and it is further

ORDERED that the Respondent may only perform a cosmetic surgical procedure in an office or a facility that is accredited by: (1) the American Association for Accreditation of Ambulatory Surgical Facilities; (2) the Accreditation Association for Ambulatory Health Care; or (3) the Joint Commission on the Accreditation of Health Care Organizations; or certified to participate in the Medicare program, as enacted by Title XVIII of the Social Security Act; 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 an evidentiary hearing before the Office of Administrative Hearings if there is a genuine dispute as to the underlying facts, or an opportunity for a show cause hearing before the Board otherwise, may impose any sanction which the Board may have imposed in this case, including probationary terms and conditions, a reprimand, suspension, revocation and/or a monetary penalty; and it is further

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

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

9/12/13
Date

Christine A. Farrelly
Christine A. Farrelly
Acting Executive Director
Maryland State Board of Physicians

CONSENT

I, **DAVID V. MARTINI, 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 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 might have followed after any such hearing.

I sign this Consent Order, voluntarily and without reservation, after having an opportunity to consult with counsel, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

9/7/13
Date

David V. Martini, M.D.

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Cecil

I HEREBY CERTIFY that on this 7 day of September, 2013, before me, a Notary Public of the foregoing State and City/County personally appear David V. Martini, 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 notary seal.

Notary Public

My commission expires:

MICHAEL D. SMIGIEL, SR
NOTARY PUBLIC
CECIL COUNTY
STATE OF MARYLAND
My Commission Expires
10-26-16