IN THE MATTER OF	*	**BEFORE THE**
ERNEST P. OSEI-TUTU, M.D.	*	**MARYLAND STATE**
Applicant D71092	*	**BOARD OF PHYSICIANS**
	*	**Case Number: 2010-0203**

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

CONSENT ORDER

On or about May 29, 2008, the Maryland State Board of Physicians (the "Board") received an Application for Initial Medical Licensure (the "Application") from **ERNEST P. OSEI-TUTU, M.D.** (the "Applicant") (Date of Birth, June 30, 1953). Based on its investigation, the Board has grounds to deny the Applicant's Application under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-401 *et seq.* (2009 Repl.vol.).

The pertinent provision of the Act under H.O. § 14-205 provides the following:

(a) *Powers.* – (1) In addition to the powers set forth elsewhere in this title, the Board may:

(iii) Subject to the Administrative Procedure Act, deny a license to an applicant or refuse to renew or reinstate an applicant's license for any of the reasons that are grounds for action under § 14-404 of this title[.]

Grounds for action under H.O. § 14-404 consist of the following:

§ 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:

(21) Is disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or

> disciplined by any branch of the United States uniformed services or the Veterans' Administration for an act that would be grounds for disciplinary action under this section[.]

Grounds for disciplinary action under H.O. § 14-404(a)(21) consist of violation of H.O. § 14-404(a):

> (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[.]

Prior to the Board's issuance of a Notice of Intent to Deny, the Applicant 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:

1. The Applicant graduated from Jefferson Medical College in Philadelphia, Pennsylvania, in 1984. He completed an internship at Cooper Hospital in New Jersey and residency in internal medicine at the New York Medical College/Westchester Medical Center in 1987.

2. The Applicant is board-certified in internal medicine.

3. The Applicant holds active medical licenses in California, Massachusetts and New York, and inactive medical license in Kentucky, Arizona, Rhode Island and Pennsylvania.

4. On or about May 28, 2008, the Applicant submitted the Application to the Board.

5. In the Application, the Applicant answered "YES" to several questions under the Fitness and Character section, including the following:

b. Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment, reprimand, suspension, or revocation.

c. Has any licensing or disciplinary board in any jurisdiction (including Maryland), or a comparable body in the armed services, filed any complaints or charges against you or investigated you for any reason?

6. Based on the Applicant's affirmative response to the Fitness and Character questions and his written explanation attached to the Application, the Board initiated an investigation of the Applicant.

7. In furtherance of its investigation, the Board requested investigatory information and documents from the Massachusetts Board of Registration in Medicine (the "Massachusetts Board") with respect to the Applicant.

8. On or about February 22, 2010, the Board received investigatory information and documents from the Massachusetts Board, which included, *inter alia*, a Final Decision and Order, a Partial Final Decision as to Findings of Fact and Conclusions of Law, and the Recommended Decision of the Administrative Magistrate, under Adjudicatory Case Number 2007-004 (RM-07-64), captioned *In the Matter of Ernest Osei-Tutu, M.D.* (collectively as the "Massachusetts Final Order"). **(A copy of the Massachusetts Final Order is attached hereto and incorporated herein).**

9. In the Massachusetts Final Order, dated February 25, 2009, the Massachusetts Board made factual and legal findings that the Applicant committed negligence and was guilty of conduct that placed into question his competence to practice medicine involving the care of a patient ("Patient A"), when he failed to meet the standard of care required of the average qualified internist in the following ways: (1)

he did not tell Patient A about the results of the his March 2003 Prostate-Specific Antigen ("PSA") test in a timely fashion; (2) he failed to repeat Patient A's March 2003 PSA test in a timely fashion; (3) on five separate occasions, he failed review pertinent medical records before treating Patient A; (4) he did not provide the consulting urologist with Patient A's relevant medical history, including his current medications, active medical problems and previous PSA levels; and (5) he did not advocate for an expedited prostate biopsy.

10. Based on its factual and legal findings, the Massachusetts Board reprimanded the Applicant and imposed a fine of seven thousand, five hundred dollars ($7,500).

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that it has the authority under H.O. § 14-205(a)(1)(iii) to deny the Applicant's Application for medical licensure in the State of Maryland.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 24th day of June, 2010, by a majority of the quorum of the Board considering this case:

ORDERED that the Applicant's Application for Initial Medical Licensure in the State of Maryland is hereby **GRANTED**; and be it further

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

ORDERED that the Applicant shall comply with the Maryland Medical Practice Act and all laws, statutes and regulations pertaining thereto; and be it further

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

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

6/24/10
Date

John T. Papavasiliou
Deputy Director
Maryland State Board of Physicians

CONSENT

I, Ernest P. Osei-Tutu, M.D., acknowledge that I have consulted with counsel or was given an opportunity to consult with counsel but voluntarily declined to do so 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 have counsel present, 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 any allegations the Board may issue. 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, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

JUNE 1, 2010
Date

Ernest P. Osei-Tutu, M.D.

NOTARY

STATE OF New Jersey

CITY/COUNTY OF Union

I HEREBY CERTIFY that on this 1st day of June, 2010, before me, a Notary Public of the foregoing State and City/County personally appear Ernest P. Osei-Tutu, M.D., Applicant, 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:

EDMUND MARQUEZ
Notary Public
State of New Jersey
My Commission Expires Aug 12, 2013

ATTACHMENT 1

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COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX, ss.

BOARD OF REGISTRATION IN MEDICINE

ADJUDICATORY CASE
NO. 2007-004 (RM-07-64)

IN THE MATTER OF

Ernest Osei-Tutu, M.D.

FINAL DECISION & ORDER

This matter came before the Board for final disposition on the basis of the Administrative Magistrate's Recommended Decision, dated July 8, 2008, and the Board's Partial Final Decision as to Findings of Fact and Conclusions of Law (hereinafter "Partial Final Decision"), dated November 19, 2008. After full consideration of that Recommended Decision and Partial Final Decision, which are attached hereto and incorporated by reference, the Board imposes the following sanction:

Sanction

The record demonstrates that the Respondent committed negligence on repeated occasions and, therefore, is guilty of conduct which places into question his competence to practice medicine. Consistent with the Board's paramount responsibility, to protect the public health, safety, and welfare, it is appropriate to impose sanction in this matter. See *Raymond v. Board of Registration in Medicine*, 387 Mass. 708 (1982); *Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1970).

In his treatment of one patient, the Respondent has been found to have: failed to tell a patient about the results of a test in a timely fashion; failed to repeat the test in a timely fashion; failed, on five separate occasions, to review pertinent medical records before treating the patient; failed to provide the patient's consulting specialist with the patient's relevant medical history, including his current medications, active medical problems and previous test results; and failed to advocate for the patient to receive an expedited biopsy.

When determining the appropriate sanction in a substandard care case, the Board takes into consideration the degree of deviation from the standard of care, the number of

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patients involved, and mitigating circumstances. Where there has been substantial deviation from the standard of care and multiple patients involved, the Board frequently has determined that revocation is the appropriate sanction. See *In the Matter of Viorel Boborodea, M.D.*, Board of Registration in Medicine, Adjudicatory Case No. 04-61-DALA (Final Decision & Order, March 15, 2006)(revocation, five patients involved). Where there is a less serious deviation from the standard of care, but repeated acts of negligence and more than one patient involved, the Board frequently has determined that suspension from practice is the appropriate sanction, with a return to practice conditioned upon entry into a monitoring agreement. See *In the Matter N. Raj Birudavol, M.D.*, Board of Registration in Medicine, Adjudicatory Case No. 02-16-DALA (Final Decision & Order, July 21, 2004)(license suspension with stay conditioned upon Probation Agreement).

In cases involving negligence in the treatment of a single patient, the Board frequently has limited the sanction to a reprimand. See *In the Matter of John Clapp, M.D.*, Board of Registration in Medicine, Adjudicatory Case No. 06-014 (Consent Order, April 12, 2006)(reprimand for failure to notify patient of abnormal test results and refer him to a specialist); *In the Matter of David Chapin, M.D.*, Board of Registration in Medicine, Adjudicatory Case No. 04-53-XX (Consent Order, November 7, 2004) (reprimand for failure to order x-ray when advised of a missing sponge).

While the instant matter is akin to *Clapp* and *Chapin* in that the negligence found involved one patient, the instant matter is distinguished in two respects. First, the Respondent's practice included a vulnerable population, prisoners, who have no choice among practitioners. Second, the Respondent was previously disciplined by the Board, for practicing with a lapsed license. See *In the Matter of Ernest Osei-Tutu*, M.D., Board of Registration in Medicine, Adjudicatory Case No. 2007-058 (Consent Order, November 14, 2007)(reprimand for practicing between July 1, and July 3, 2005, after his license lapsed on June 30, 2005). "Evidence of past misconduct...has been essential in determining the appropriate level of discipline to be imposed in any case." See *Matter of Saab*, 406 Mass. 315, 327-328 (1989).

Consistent with Board precedent concerning negligence in the treatment of a single patient and, in light of the Respondent's treating a vulnerable population and having been previously disciplined by the Board, the Board hereby REPRIMANDS the Respondent and

FINES the Respondent seven thousand, five hundred dollars ($7,500). Said fine is payable within ninety days from the date of the execution of this Order. This sanction is imposed for docket number 04-606. The Board will not renew the license of any physician who fails to pay a fine in a timely manner; this step will be taken automatically and no further notice or process will apply.

The Respondent shall provide a complete copy of this Final Decision and Order, with all exhibits and attachments, within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: the Drug Enforcement Administration, Boston Diversion Group; any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which he practices medicine; any in- or out-of-state health maintenance organization with whom he has privileges or any other kind of association; any state agency, in- or out-of-state, with which he has a provider contract; any in- or out-of-state medical employer, whether or not he practices medicine there; the Drug Enforcement Administration Boston Diversion Group; the Bureau of Health Care Safety and Quality, Massachusetts Department of Public Health; and the state licensing boards of all states in which he has any kind of license to practice medicine. The Respondent shall also provide this notification to any such designated entities with which he becomes associated in the year following the Board's issuance of this Final Decision and Order. The Respondent is further directed to certify to the Board within ten (10) days that he has complied with this directive.

The Respondent has the right to appeal this Final Decision and Order within thirty (30) days, pursuant to G.L. c. 30A, §§ 14 and 15, and G.L. c. 112, § 64.

Date: February 25, 2009

Peter Paige, M.D.
Vice-Chairman

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COMMONWEALTH OF MASSACHUSETTS

BOARD OF REGISTRATION IN MEDICINE

Suffolk, ss.

Adjudicatory Case
No. 2007-004
(RM-07-64)

In the Matter of

Ernest Osei-Tutu, M.D.

Partial Final Decision as to Findings of Fact and Conclusions of Law

This matter came before the Board on the basis of the Administrative Magistrate's Recommended Decision, dated July 8, 2008, for disposition as to Findings of Fact and Conclusions of Law Only. After full consideration of that Recommended Decision, which is attached hereto and incorporated by reference, Respondent's Objections and Complaint Counsel's Response, the Board hereby adopts that Recommended Decision as a Partial Final Decision.

After the Board hears from the parties on the issue of sanction, it will issue a complete Final Decision and Order, including any sanction and notification requirements.

DATE: November 19, 2008

John B Herman MD

John B. Herman, M.D.
Chairman

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COMMONWEALTH OF MASSACHUSETTS

Suffolk, ss.

Division of Administrative Law Appeals
98 N. Washington Street
Boston, Massachusetts 02114
(617) 727-7060

Board of Registration in Medicine,
Petitioner,

Docket No.: RM-07-64

v.

Ernest Osei-Tutu, M.D.,
Respondent.

Appearance for Petitioner:

Tracy Morong, Esq.
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118

Appearance for Respondent:

David A. Hilton, Esq.
Morrison Mahoney LLP
250 Summer Street
Boston, Massachusetts 02210

Administrative Magistrate:

Natalie S. Monroe, Esq.

RECOMMENDED DECISION

On January 24, 2007, the Board of Registration in Medicine (the "Board") issued a Statement of Allegations against Ernest Osei-Tutu, M.D., alleging that he had engaged in conduct that calls into question his license to practice medicine, including negligence on repeated occasions in the care of a patient (Patient A). On that same date, the Board allowed a motion to impound and to use pseudonyms and referred the matter to the Division of Administrative Law Appeals for a full hearing.

I held a hearing at the offices of the Division of Administrative Law Appeals, 98 North Washington Street, Boston on October 24, 2007; October 25, 2007; and January 8,

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2008. Six exhibits were entered into evidence during the hearing and three witnesses testified: Ernest Osei-Tutu, Edwin Knights and Jerome Siegel.

The record closed on March 10, 2008, with the submission of post-hearing briefs.

Findings of Fact

Based on all of the evidence presented, reasonable inferences drawn from the evidence, and my assessment of the credibility of the witnesses, I make the following findings of fact.

1. Ernest Osei-Tutu was born on June 30, 1953. He graduated from the Thomas Jefferson Medical College of Thomas Jefferson University in 1984. He was first licensed to practice medicine in Massachusetts in 1992 and was board certified in internal medicine in 1994. (Tr. I, pp. 26-27, 144).[1]

2. From September 2001 to January 2005, Dr. Osei-Tutu served as the Medical Director for Correctional Medical Services at MCI-Norfolk. (Tr. I, pp. 29, 146, 148).

3. MCI-Norfolk is a medium-security prison that houses approximately 1,800 inmates. (Tr. I, p. 148).

4. As the Medical Director, Dr. Osei-Tutu was responsible for overseeing all of the inmates' medical care. In this capacity, Dr. Osei-Tutu supervised six nurse practitioners and two physicians. (Tr. I, pp. 29-30, 31, 148).

5. In addition to his supervisory responsibilities at MCI-Norfolk, Dr. Osei-Tutu also treated inmates who came into the clinic. (Tr. I, pp. 29-30).

[1] There is a three-volume stenographic record of the hearing; each volume corresponds to one day of hearing. Testimony given during the hearing is cited as follows: "Tr.", followed by the transcript volume number (e.g., "II"), followed by the relevant pages in the transcript. "Exh. __" refers to an exhibit marked into evidence at the hearing.

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6. During his tenure at MCI-Norfolk, Dr. Osei-Tutu saw an average of twenty patients a day, for an average of one hundred patients per week. (Tr. I, pp. 32-33).

7. During the time that Dr. Osei-Tutu worked at MCI-Norfolk – from September 2001 to January 2005 – inmates were not assigned to specific health care providers. Inmates would see whichever provider was available as necessary. (Tr. I, pp. 31, 148-49).

8. Between 2001 and 2005, inmates could be seen by a health care provider for a sick call visit, a chronic disease visit, or a physical examination. (Tr. I, p. 148).

9. Between 2001 and 2005, a sick call was a visit with a health care provider to address an acute medical issue, such as a skin rash or a broken dental plate. An inmate requested a sick visit by submitting a sick slip to the clinic. A sick visit was limited to approximately fifteen minutes. (Tr. I, pp. 31, 159-60; Exh. 1 at pp. 179, 201).

10. Between 2001 and 2005, a chronic disease visit was a visit with a health care provider to address an ongoing medical problem, such as hypertension or diabetes. (Tr. I, pp. 159-60).

11. Between 2001 and 2005, inmates with chronic diseases had to be seen for a chronic disease visit every three months. A chronic disease visit was allotted approximately twenty-five minutes. (Tr. I, pp. 159-60).

12. Between 2001 and 2005, inmates had a physical exam every year. (Tr. I, p. 149).

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13. Between 2001 and 2005, doctors and nurse practitioners at MCI-Norfolk were limited as to what time of the day they could see inmates for treatment. At approximately 11:15 a.m. and 4:00 p.m. every day, inmates had to return to their cells for a head count even if it meant missing an appointment with a health care provider. (Tr. I, pp. 149-50).

Patient A

14. Patient A is an adult Hispanic male who was transferred to MCI-Norfolk in early 2002. He was in his early fifties and he suffered from a chronic skin rash, urinary tract problems, borderline elevated cholesterol and borderline elevated blood pressure. (Tr. I, pp. 33-35; Exh. 1 at pp. 165, 192).

15. Dr. Osei-Tutu first treated Patient A on June 11, 2002, for a sick visit relating to his skin rash. (Tr. I, pp. 34, 41).

16. Dr. Osei-Tutu next saw Patient A on June 28, 2002, for a sick visit to discuss a June 27, 2002 dermatology consultation that Patient A had had at Lemuel Shattuck Hospital. (Tr. I, pp. 40-41; Exh. 1 at p. 151).

17. Dr. Osei-Tutu wrote progress notes on August 19, 2002 and September 9, 2002 concerning health care visits with Patient A. (Exh. 1 at pp. 152, 154).

18. Dr. Osei-Tutu saw Patient A again on October 11, 2002. This was a sick visit for dysuria, which is painful urination. (Tr. I, pp. 39-46; Exh. 1 at p. 155).

19. During the October 11, 2002 visit, Patient A indicated that he "thought his prostate was bothering [him] again." Dr. Osei-Tutu indicated in his notes that Patient A had experienced pain/painful urination for "a couple of weeks." Patient A was not in acute distress. (Tr. I, pp. 45-46; Exh. 1 at p. 155).

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20. During the October 11, 2002 visit, Dr. Osei-Tutu took Patient A's vital signs and performed a physical examination, including a digital rectal examination to check Patient A's prostate. (Tr. I, pp. 45-47).

21. Dr. Osei-Tutu noted that Patient A's prostate was not enlarged and that it had no nodules on it. Dr. Osei-Tutu also noted that the prostate was not warm, but that there was questionable tenderness. (Tr. I, pp. 45-46; Exh. 1 at p. 155).

22. Dr. Osei-Tutu's provisional diagnosis was prostatitis, which is inflammation of the prostate. (Tr. I, pp. 45-48; Exh. 1 at p. 155).

23. Dr. Osei-Tutu created a treatment plan, which consisted of prescribing antibiotics, performing a urinalysis, obtaining a urine culture and checking Patient A's prostate-specific antigen ("PSA") level. (Tr. I, pp. 45-46, 48; Exh. 1 at p. 849).

24. PSA is a protein in the blood stream that serves as a marker for prostate tissue. (Tr. II, pp. 288-89).

25. Normal PSA levels range from 0 ng/ml to 4 ng/ml. A PSA level above 4 ng/ml is considered out of the normal range. (Tr. I, pp. 103-04, 118-19; Tr. II, p. 207).

26. In 2002 and 2003, PSA tests were used as a screening tool for prostate cancer. (Tr. II, pp. 185-86).

27. While a patient's PSA level can be used as a screening tool, an elevated PSA level is not a definitive diagnosis of prostate cancer. Prostate cancer can only be diagnosed by performing a prostate biopsy. (Tr. I, p. 49; Tr. II, pp. 289-90).

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28. A patient can have an elevated PSA level for reasons other than prostate cancer, such as prostatitis or a benign enlargement of the prostate. (Tr. I, pp. 96-99).

29. Dr. Osei-Tutu ordered the PSA test in October 2002 because urinary tract problems are unusual in men. Consequently, when Patient A complained of burning on urination, Dr. Osei-Tutu thought the problem might be related to his prostate. (Tr. I, pp. 52-53).

30. In the treatment plan that Dr. Osei-Tutu developed during Patient A's October 11, 2002 sick visit, he ordered that the tests, including the PSA test, be done as soon as possible. (Tr. I, p. 53; Exh. 1 at p. 849).

31. Dr. Osei-Tutu wanted the tests completed as soon as possible because his physical examination of Patent A was not conclusive and therefore his diagnosis of prostatitis was not definite. (Tr. I, p. 53).

32. On or about October 21, 2002, Dr. Osei-Tutu received the test results that he had ordered for Patient A. Patient A's PSA level was 2.53, which was within the normal limits. All of the other test results also were within normal limits. (Tr. I, pp. 54, 56; Exh. 1 at p. 514).

33. Dr. Osei-Tutu saw Patient A on November 26, 2002 for a chronic disease visit. (Tr. I, p. 58; Exh. 1 at p. 161).

34. Dr. Osei-Tutu saw Patient A on December 2, 2002 for a sick visit related to a facial rash. (Tr. I, pp. 58, 70-71; Exh. 1 at p. 162).

35. On January 28, 2003, Dr. Osei-Tutu signed a consultation report from Dr. Asvadi, a dermatologist at Lemuel Shattuck Hospital ("LSH") who treated

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Patient A on January 16, 2003. The referral stated, in part, "Important: patient needs follow up urology appointment for dysuria at LSH." (Tr. I, pp. 60-62; Exh. 1 at p. 165).

36. There is no evidence in the record that the urology appointment was scheduled. (Tr. I, pp. 62-63).

37. On or about March 31, 2003, a nurse practitioner under Dr. Osei-Tutu's supervision gave Patient A a physical examination, which included performing a digital rectal examination to check Patient A's prostate. The nurse practitioner also ordered a PSA test for Patient A. (Tr. I, p. 63; Exh. 1 at p. 862).

38. In 2003; it was part of Dr. Osei-Tutu's responsibilities as Medical Director to review every lab result for every patient regardless of whether he had ordered the tests. (Tr. I, pp. 64-65).

39. On April 2, 2003, Dr. Osei-Tutu received and reviewed the results of the PSA test that the nurse practitioner had ordered for Patient A. (Tr. I, p. 65; Exh. 1 at p. 519).

40. The test indicated that Patient A's PSA level was 5.53, which was out of the normal range. (Tr. I, p. 66; Exh. 1 at p. 519).

41. A PSA level between 4 and 10 is indicative of a twenty-five percent chance of prostate cancer. It also can be indicative of an enlarged or inflamed prostate. (Tr. I, pp. 96-97; Exh. 1 at p. 519).

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42. Dr. Osei-Tutu's customary practice at that time was to sign off on all abnormal lab results and to have the patient's chart pulled for his review. (Tr. I, pp. 55-56).

43. When an inmate had an abnormal test result, it also was Dr. Osei-Tutu's practice to speak with the patient about the lab result and to repeat the test to make sure the first test was accurate. (Tr. I, pp. 55-56).

44. After reviewing Patient A's PSA test result, Dr. Osei-Tutu signed the lab result and requested Patient A's chart for his review. (Tr. I, pp. 66-67).

45. On April 3, 2003, Dr. Osei-Tutu also issued a physician's order requesting that Patient A come and see him for a sick call regarding the elevated PSA. (Tr. I, pp. 67-68; Exh. 1 at p. 169).

46. Dr. Osei-Tutu ordered Patient A to see him because he wanted to tell Patient A that his PSA level was elevated. Dr. Osei-Tutu also wanted to repeat the PSA test to ensure that the first test had been accurate. (Tr. I, pp. 69-70).

47. Patient A's medical records for April 3, 2003 indicate that a nurse practitioner noted Dr. Osei-Tutu's order to have Patient A return for a sick visit with Dr. Osei-Tutu. (Exh. 1 at p. 169).

48. In April 2003, Dr. Osei-Tutu relied on his staff to ensure that his orders were carried out. (Tr. I, pp. 69-70).

49. Patient A did not return to see Dr. Osei-Tutu as ordered. (Tr. I, pp. 70, 71).

50. Dr. Osei-Tutu next saw Patient A on June 11, 2003. This was a sick call for a facial rash. (Tr. I, p. 70; Tr. II, pp. 194-95; Exh. 1 at p. 175).

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51. When Dr. Osei-Tutu saw Patient A on June 11, 2003, he treated Patient A for his facial rash only. Dr. Osei-Tutu did not review Patient A's previous test results. He did not review Patient A's medical records to determine whether there were any outstanding orders. (Tr. I, pp. 71-73; Exh. 1 at p. 175).

52. At the June 11, 2003 sick visit, Dr. Osei-Tutu did not tell Patient A that he had had an elevated PSA level in March of 2003. Dr. Osei-Tutu did not order another PSA test for Patient A. (Tr. I, pp. 71-73; Tr. II, pp. 195, 196-98; Exh. 1 at pp. 175, 177).

53. Dr. Osei-Tutu saw Patient A again on June 23, 2003. This was a sick call for a facial rash. (Tr. II, pp. 196-97; Exh. 1 at p. 175).

54. When Dr. Osei-Tutu saw Patient A on June 23, 2003, he treated Patient A for his facial rash only. Dr. Osei-Tutu did not review Patient A's previous test results. He did not review Patient A's medical records to determine whether there were any outstanding orders. (Tr. II, pp. 196-97; Exh. 1 at p. 175).

55. At the June 23, 2003 sick visit, Dr. Osei-Tutu did not tell Patient A that he had had an elevated PSA level in March of 2003. Dr. Osei-Tutu did not order another PSA test for Patient A. (Tr. II, pp. 196-97; Exh. 1 at p. 175).

56. On June 25, 2003, Dr. Osei-Tutu wrote a physician's order for blood tests for Patient A. The physician's order did not include a PSA test. (Tr. II, p. 198; Exh. 1 at p. 176).

57. On July 23, 2003, one of Dr. Osei-Tutu's colleagues, Dr. Stankiewicz, saw Patient A for a chronic disease visit. (Tr. I, pp. 73-75).

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58. Dr. Osei-Tutu saw Patient A again on October 9, 2003. This was a sick visit for facial dermatitis and for pain in Patient A's leg. (Tr. I, pp. 80-81; Exh. 1 at p. 181).

59. When he saw Patient A on October 9, 2003, Dr. Osei-Tutu treated only his skin rash. He did not review Patient A's previous test results. He did not review Patient A's medical records to determine whether there were any outstanding orders. (Tr. I, pp. 81, 84).

60. On October 9, 2003, Dr. Osei-Tutu did not tell Patient A that he had had an elevated PSA level in March of 2003. Dr. Osei-Tutu did not order another PSA test for Patient A. (Tr. I, p. 84; Tr. II, pp. 202-03).

61. On October 10, 2003, Dr. Osei-Tutu performed a punch biopsy on Patient A's left leg. (Tr. I, p. 85; Exh. 1 at p. 187).

62. At the October 10, 2003 visit, Dr. Osei-Tutu did not review Patient A's previous test results. He did not review Patient A's medical records to determine whether there were any outstanding orders. (Tr. I, p. 85; Exh. 1 at p. 187).

63. On October 10, 2003, Dr. Osei-Tutu did not tell Patient A that he had had an elevated PSA level in March of 2003. Dr. Osei-Tutu did not order another PSA test for Patient A. (Tr. I, p. 85; Tr. II, pp. 204-05; Exh. 1 at p. 187).

64. Dr. Osei-Tutu next saw Patient A on October 21, 2003. This was a sick visit for a skin rash. (Tr. I, pp. 85-86; Exh. 1 at pp. 187-88).

65. At the October 21, 2003 visit, Dr. Osei-Tutu did not review Patient A's previous test results. He did not review Patient A's medical records to

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determine whether there were any outstanding orders. (Tr. I, pp. 86-87; Exh. 1 at pp. 187-88, 205).

66. On October 21, 2003, Dr. Osei-Tutu did not tell Patient A that he had had an elevated PSA level in March of 2003. (Tr. I, pp. 85-86; Exh. 1 at pp. 187-88).

67. During the October 21, 2003 visit, Dr. Osei-Tutu ordered a series of tests, including a urinalysis and a complete blood count. He did not order a repeat PSA test. (Tr. I, pp. 86-87; Exh. 1 at p. 874).

68. Dr. Osei-Tutu next saw Patient A on October 30, 2003. This was a chronic disease visit for Patient A's high cholesterol. (Tr. I, pp. 87-88; Exh. 1 at p. 188).

69. During the October 30, 2003 visit, Dr. Osei-Tutu performed a physical examination, which was unrevealing. Dr. Osei-Tutu did not perform a digital rectal exam. (Tr. I, pp. 90-91).

70. As part of the visit, Dr. Osei-Tutu reviewed Patient A's most recent lab results, as well as Dr. Stankiewicz's report from the July 23, 2003 chronic disease visit. In his report, Dr. Stankiewicz noted that Patient A's March 2003 PSA test had never been repeated. (Tr. I, pp. 160-61).

71. When he read Dr. Stankiewicz's report, Dr. Osei-Tutu realized that Patient A's March 2003 PSA test had never been repeated. (Tr. I, pp. 160-61).

72. During the October 30, 2003 visit, Dr. Osei-Tutu talked to Patient A about the March 2003 PSA test results and ordered another PSA test. (Tr. I, pp. 89, 91, 92-93; Exh. 1 at p. 875).

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73. The PSA test was completed on November 5, 2003. It indicated that Patient A's PSA level was 6.90, which was above the normal limits. (Tr. I, p. 93; Exh. 1 at p. 529).

74. Patient A's PSA level in October of 2002 was 2.53, meaning that his PSA level more than doubled between October 2002 and November 2003. This was a significant and rapid increase. (Tr. I, pp. 103-04; Tr. II, pp. 207-08).

75. Dr. Osei-Tutu reviewed the November 5, 2003 PSA results on November 7, 2003. He then ordered Patient A's chart pulled for his review. (Tr. I, pp. 93-94).

76. The chart was pulled for Dr. Osei-Tutu and he reviewed it on November 12, 2003. He issued an order to have the PSA test repeated to ensure accuracy. He also requested that Patient A make an appointment to see him about his elevated PSA level. (Tr. I, pp. 94, 99, 101; Exh. 1 at p. 877).

77. Dr. Osei-Tutu also planned to send Patient A to a urologist for a consultation, with the expectation that the urologist would perform a prostate biopsy to check for cancer. (Tr. I, pp. 49, 103-04, 129-30, 163).

78. Dr. Osei-Tutu could not perform the prostate biopsy himself because he was an internist and the procedure had to be performed by a urologist. (Tr. I, pp. 129-30; Tr. II, pp. 247-48, 250-51)..

79. Dr. Osei-Tutu saw Patient A again on November 17, 2003. This was a sick visit for a facial rash and for pain in Patient A's leg and back. (Tr. I, pp. 102-03; Exh. 1 at pp. 190-91).

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80. When he saw Patient A on November 17, 2003, Dr. Osei-Tutu discussed the significance of the elevated PSA and told Patient A that he was going to send him to a urologist for a consultation. (Tr. I, pp. 103, 130-31; Exh. 1 at p. 190).

81. During the visit, Dr. Osei-Tutu realized that his November 12, 2003 order for a repeat PSA had not been carried out. He therefore repeated his order for the PSA test. (Tr. I, p. 111; Exh. 1 at p. 878).

82. When he saw Patient A on November 17, 2003, Dr. Osei-Tutu did not perform a digital rectal exam because he believed the urologist would perform one. (Tr. I, pp. 105-06; Exh. 1 at p. 190).

83. At the November 17, 2003 visit, Dr. Osei-Tutu filled out a request for a urology consult. (Tr. I, p. 110; Exh. 1 at p. 192).

84. In November of 2003, the Regional Medical Director of Correctional Medical Services had to approve all initial consultation requests. (Tr. I, pp. 163-64).

85. Dr. Osei-Tutu submitted the urologist consult request on November 17, 2003. In his request, Dr. Osei-Tutu wrote that Patient A was a "42-year-old [*sic*] Hispanic male with increased PSA (6.90)." The request did not include Patient A's PSA test results from October 2002 or March 2003. (Tr. I, pp. 112-13; Exh. 1 at p. 192).

86. Dr. Osei-Tutu gave the consultation request to the staff secretary on November 17, 2003. (Tr. I, pp. 113-14).

87. In November 2003, it typically took between a month and six weeks for an inmate to see a urologist pursuant to a consultation request. (Tr. I, pp. 116-17, 120).

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88. When Dr. Osei-Tutu gave the consultation request to the staff secretary, he did not give her any special instructions about when the urology consult should be scheduled. (Tr. I, pp. 115-16, 120; Exh. 1 at p. 192).

89. Dr. Osei-Tutu did not ask to expedite the urology consult because he felt that the urologist could see Patient A's PSA level of 6.90 and could determine for himself when the consultation should take place. (Tr. I, pp. 116-17, 120).

90. In addition, Dr. Osei-Tutu did not feel there was any reason to expedite the consultation. First, he did not believe there was a correlation between the early diagnosis of prostate cancer and survival rates. Second, Patient A's digital rectal examination in March of 2003 had been unremarkable; Dr. Osei-Tutu therefore believed that if Patient A had prostate cancer, it was microscopic. (Tr. I, pp. 116-17, 120, 161-62).

91. Patient A's urology consultation was scheduled for December 26, 2003 with Dr. Klotkin at Lemuel Shattuck Hospital ("LSH"). (Tr. I, p. 117; Exh. 1 at p. 197).

92. Dr. Osei-Tutu was required to send Patient A to LSH for the urology consult. He was only allowed to send an inmate to another facility if LSH did not have the necessary medical expertise. (Tr. I, pp. 162-63).

93. Dr. Osei-Tutu did not order to have Patient A's medical records sent to Dr. Klotkin in advance of the consultation. In 2003, it was Dr. Osei-Tutu's practice to forward an inmate's medical records to a consulting physician only if the physician requested them. (Tr. I, p. 115).

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94. Dr. Osei-Tutu received a copy of Dr. Klotkin's urology consult report on December 31, 2003. (Tr. I, pp. 120-21; Exh. 1 at p. 197).

95. In his report, Dr. Klotkin stated that he wanted to perform an ultrasound-guided prostate biopsy on Patient A. He requested that the procedure be scheduled for February 2, 2004, at LSH. (Tr. I, pp. 122-24; Exh. 1 at p. 198).

96. After reviewing Dr. Klotkin's report, Dr. Osei-Tutu ordered a nurse practitioner, Mark Clarke, to schedule the ultrasound-guided biopsy for Patient A. (Tr. I, pp. 121-23).

97. Nurse Practitioner Clarke filled out the necessary paperwork on January 3, 2004. Dr. Osei-Tutu signed the paperwork on January 5, 2004, and gave it to the staff secretary, who was responsible for scheduling tests and appointments. (Tr. I, pp. 123-25).

98. During his time at MCI-Norfolk, Dr. Osei-Tutu could not dictate when a consultation or biopsy was performed; it was up to the doctor performing the consultation or biopsy to determine when it would take place. (Tr. I, p. 169; Tr. II, pp. 257-58).

99. During his time at MCI-Norfolk, Dr. Osei-Tutu did not schedule appointments outside of the facility. The staff secretary was responsible for coordinating all such scheduling. (Tr. I, pp. 114, 126-27).

100. Patient A's biopsy initially was scheduled for February 2, 2004. (Tr. I, p. 126).

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101. For reasons out of Dr. Osei-Tutu's control, Patient A's biopsy was re-scheduled from February 2, 2004 to February 20, 2004, and then to March 2, 2004. (Tr. I, pp. 126-27, 133).

102. The biopsy revealed that Patient A had prostate cancer. (Tr. I, p. 132).

Standard of Care

103. When a patient with a history of normal PSA levels and unremarkable digital rectal examinations has an elevated PSA test result, the standard of care in 2003 for an average qualified internist required telling the patient about his elevated PSA level within a month after receiving the test result. (Tr. II, p. 189).

104. When a patient with a history of normal PSA levels and unremarkable digital rectal examinations has an elevated PSA test result, the standard of care in 2003 for an average qualified internist also required either repeating the PSA test or treating the patient with antibiotics and then repeating the test. In either case, the standard of care for an average qualified internist in 2003 required repeating the PSA test within six weeks after the first test. (Tr. II, pp. 187-90).

105. In 2003, the standard of care for an average qualified internist required repeating the PSA test within six weeks for two reasons: (1) to rule out a false positive; and (2) to see if the PSA was briefly elevated because of a low-grade prostate infection. (Tr. II, pp. 190, 235-36).

106. In 2003, if the repeat PSA test had been within normal limits, the standard of care for an average qualified internist required repeating the PSA test within

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six months. If the repeat PSA test had remained elevated, the standard of care for an average qualified internist in 2003 required a more aggressive treatment plan. (Tr. II, pp. 190, 239).

107. When a patient has had an elevated PSA test result and the test was not repeated within six weeks, the standard of care in 2003 for an average qualified internist required telling the patient about the results at the patient's next health care visit. (Tr. II, pp. 195-96, 198, 203, 205-06).

108. When a patient has had an elevated PSA test result and the test was not repeated within six weeks, the standard of care in 2003 for an average qualified internist required repeating the PSA test at the patient's next health care visit. (Tr. II, pp. 195-96, 198, 203, 205-06).

109. In 2003, the standard of care for an average qualified internist required reviewing the following information as part of every patient visit, including a sick visit: the patient's problem list, active medications, most-recent lab results and most-recent visits with health care providers. (Tr. II, pp. 220-21).

110. When a patient's PSA level has more than doubled in one year and has been elevated for seven months, the standard of care in 2003 for the average qualified urologist required conducting a consultation within two weeks and performing a biopsy within four weeks. (Tr. II, pp. 207-08, 212).

111. When requesting a urology consultation for a patient with a PSA level that has more than doubled in one year and that has been elevated for seven months, the standard of care in 2003 for the average qualified internist

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required asking the urologist to schedule a prostate biopsy on a expedited basis. (Tr. II, pp. 207-08, 260-61).

112. When sending a patient for a urology consult due to an elevated PSA level, the standard of care in 2003 for the average qualified internist required providing the consulting urologist with the patient's relevant medical history, including his previous PSA test results, current medications and active medical problems. (Tr. II, pp. 208-09).

Discussion

The Board has the authority to discipline a physician "who is guilty of conduct which places into question the physician's competence to practice medicine, including ... negligence on repeated occasions." G.L. c. 112, § 5(c). Negligence includes, among other things, the failure to meet generally accepted standards of care within the medical community. See, e.g., Board of Registration in Med. v. Thomas Schultz, M.D., RM-91-219 (DALA dec. 7/10/97; Fin. Dec. & Order 12/17/97). See also Altman v. Aronson, 231 Mass. 588, 591-92, 121 N.E. 505, 506 (1919) (negligence "is the failure of a responsible person ... to exercise [the required] degree of care, vigilance and forethought ... in the discharge of the duty then resting on him").

After carefully considering all of the evidence, I find that the Board has met its burden of proving by a preponderance of the evidence that Dr. Osei-Tutu was negligent on repeated occasions because he failed to meet the standard of care required of the average qualified internist in the following ways: (1) he did not tell Patient A about the results of his March 2003 PSA test in a timely fashion; (2) he failed to repeat Patient A's March 2003 PSA test in a timely fashion; (3) on five separate occasions, he failed to

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review pertinent medical records before treating Patient A; (4) he did not provide the consulting urologist with Patient A's relevant medical history; and (5) he did not advocate for an expedited prostate biopsy for Patient A.

The Board did not meet its burden of proving that Dr. Osei-Tutu failed to have an adequate system in place to ensure that physician orders were carried out. Moreover, the Board contends in its closing brief that Dr. Osei-Tutu's conduct rises to the level of gross negligence. See, e.g., G.L. c. 112, § 5(c) (the Board can discipline physicians who are guilty of gross negligence). The Board's Statement of Allegations did not charge Dr. Osei-Tutu with gross negligence, however. As a result, this charge is not properly before me.

1. Failing to Tell Patient A About the March 2003 PSA Results.

The standard of care in 2003 for the average qualified internist required that Dr. Osei-Tutu tell Patient A about his elevated PSA level within a month of receiving the test results. Dr. Osei-Tutu received Patient A's PSA test results on April 2, 2003 and he talked to Patient A about the results on October 30, 2003, nearly seven months later. Dr. Osei-Tutu's conduct therefore fell below the prevailing standard of care.

Dr. Osei-Tutu correctly points out that a day after receiving the March 2003 PSA results, he tried to schedule an appointment with Patient A and there is no proof that it was his fault that the visit did not occur. In particular, on April 3, 2003, Dr. Osei-Tutu issued an order to have Patient A schedule a sick visit to see him about his PSA level. A nurse practitioner noted Dr. Osei-Tutu's order, which indicates that he or she acted on it.

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Moreover, while Patient A did not return for the requested sick visit, there is no evidence that Dr. Osei-Tutu was responsible for the lapse.[2]

This does not mean that Dr. Osei-Tutu met the requisite standard of care, however. Dr. Osei-Tutu saw Patient A on June 11, 2003; June 23, 2003; October 9, 2003; October 10, 2003; and October 21, 2003, yet he did not discuss the March 2003 PSA test at any of those visits. Given that the standard of care required Dr. Osei-Tutu to talk to Patient A within a month after getting the first results, it was incumbent upon him to speak to Patient A about the PSA test at these later visits. See Findings of Fact No. 107. By failing to discuss the PSA test with Patient A until October 30, 2003, Dr. Osei-Tutu failed to meet the standard of care in 2003 for an average qualified internist.

2. Failing to Repeat Patient A's March 2003 PSA Test in a Timely Fashion.

The standard of care in 2003 for the average qualified internist required that Dr. Osei-Tutu repeat the PSA test within six weeks of receiving the first test results. In this case, Dr. Osei-Tutu received the PSA lab report on April 2, 2003, but did not order a repeat test until October 30, 2003, seven months after the first test. As previously discussed, Dr. Osei-Tutu saw Patient A on June 11, 2003; June 23, 2003; October 9, 2003; October 10, 2003; and October 21, 2003, but did not repeat the test during any of these visits.

Moreover, on June 25, 2003, Dr. Osei-Tutu wrote a physician's order for blood tests for Patient A, but he did not include a repeat PSA test. His failure to order the repeat test at that time fell below the standard of care in 2003 for the average qualified

[2] Patient A could have missed the sick visit for many reasons that had nothing to do with Dr. Osei-Tutu. For example, perhaps Patient A received the order, but did not follow up on it. Or perhaps Patient A tried to see Dr. Osei-Tutu, but had to return to his cell for a head count before the appointment occurred. See, e.g., Tr. I, pp. 149-50 (inmates had to return to their cells twice a day for a head count).

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internist. In addition, the June 25, 2003 order demonstrates that Dr. Osei-Tutu did not have to schedule a health care visit before ordering tests for inmates. This means that Dr. Osei-Tutu could have issued an order for the repeat PSA test anytime after he received the March 2003 lab report. By failing to repeat the PSA test until October 30, 2003, Dr. Osei-Tutu failed to meet the standard of care in 2003 for an average qualified internist.

Dr. Osei-Tutu's expert witness, Dr. Jerome Siegel, testified that the standard of care required Dr. Osei-Tutu to repeat the PSA test within two years. See, e.g., Tr. II, pp. 299, 303. Having observed Dr. Siegel, and having weighed his testimony against the rest of the evidence, I do not credit his testimony on this point. Dr. Siegel was evasive and gave intentionally convoluted answers to straightforward questions. For instance, when asked about the standard of care for a patient with an abnormal PSA level, Dr. Siegel instead discussed routine prostate cancer screening for healthy men. See, e.g., Tr. II, pp. 299-300. Such responses were evasive and unhelpful.

Additionally, Dr. Siegel's testimony does not make logical sense. He testified, for example, that Patient A's PSA level needed to be repeated to ensure that the first test was accurate, yet he felt the test could have been repeated within two years. Given that PSA levels can fluctuate over time, waiting two years to repeat the test would not have indicated whether the original test was a false positive. Similarly, Dr. Siegel testified that in 2003 the general guidelines from medical associations recommended that men over fifty get a routine PSA test to screen for prostate cancer once a year. Tr. II, pp. 299-300. It makes no sense that the standard of care required repeating an elevated PSA test in two years when healthy males with normal PSA levels should be tested every year. Because

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Dr. Siegel's testimony on the applicable standard of care was both evasive and incredible, I did not give it any weight.

In contrast, I found Dr. Knights, who testified on the Board's behalf, to be candid, direct and truthful. Moreover, his testimony was compatible with the balance of the evidence. For instance, Dr. Osei-Tutu testified that he had intended to repeat the March PSA test right away to ensure accuracy; this is consistent with Dr. Knights's testimony that Patient A should have been re-tested within six weeks to rule out a false positive. I therefore accept Dr. Knights's testimony concerning the standards of care at issue in this case, including the standard of care for repeating an abnormal PSA test.

In sum, by failing to order the repeat PSA test until October 30, 2003, Dr. Osei-Tutu's conduct fell below the applicable standard of care in 2003 for an average qualified internist.

3. Failing to Review Pertinent Portions of Patient A's Medical Records

In 2003, the standard of care for the average qualified internist required reviewing the following information as part of every patient visit, including a sick visit: the patient's problem list, active medications, most-recent lab results and most-recent visits with health care providers. When Dr. Osei-Tutu saw Patient A for sick visits on June 11, 2003; June 23, 2003; October 9, 2003; October 10, 2003; and October 21, 2003, he did not review Patient A's problem list, most-recent lab results, current medications or most-recent visits with health care providers. He therefore violated the pertinent standard of care.

Dr. Osei-Tutu argues that he did not have time to review any part of an inmate's medical records in connection with a sick visit. He testified that because sick visits were

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allotted fifteen minutes, he could only treat the inmate's immediate problem and could not look at the inmate's previous lab results or other aspects of his medical records. I did not find this testimony to be credible. Dr. Osei-Tutu's other testimony, as well as his own orders and progress notes, demonstrate that he did have time to review portions of patients' medical records in connection with sick visits. See, e.g., Tr. I, pp. 68-69, 103, 150-60 (Dr. Osei-Tutu sometimes reviewed progress reports, lab results, x-rays and image studies during sick visits). Moreover, to accept Dr. Osei-Tutu's argument, I would have to accept that inmates are entitled to a lower standard of medical care than the rest of the population, a proposition that I cannot adopt.

I therefore conclude that Dr. Osei-Tutu's care of Patient A fell below the prevailing standard of care in 2003 because he failed to review Patient A's most-recent lab results, problem list, current medications and most-recent visits with care providers before treating Patient A. Dr. Osei-Tutu failed to meet this standard of care during five sick visits that occurred on the following dates: June 11, 2003; June 23, 2003; October 9, 2003; October 10, 2003; and October 21, 2003.

4. Failing to Provide Relevant Information to Dr. Klotkin.

When sending a patient for a urology consult due to an elevated PSA level, the standard of care in 2003 for the average qualified internist required providing the consulting urologist with the patient's relevant medical history, including his medications, active medical problems and previous PSA test results. Dr. Osei-Tutu's request for a urology consult stated only that Patient A was a "42-year old [*sic*] Hispanic male with increased PSA (6.90)." The order did not include any information about Patient A's current medical problems or his medications. Nor did the order include

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Patient A's PSA test results from October of 2002 and March of 2003. I accept Dr. Knights's testimony that the earlier PSA test results were especially important because they put the November PSA results in perspective. Specifically, they showed that Patient A's PSA levels had more than doubled in one year, which was a dramatic increase for a man of Patient A's age and which indicated that Patient A required prompt treatment.

During the hearing, Dr. Osei-Tutu and his counsel contended that the consulting urologist, Dr. Klotkin, could have requested Patient A's entire medical record if he wanted it. This is a red herring. The purpose of this case is to review Dr. Osei-Tutu's conduct in relation to the applicable standard of care. In this instance, his obligation was to provide the consulting urologist with a limited set of relevant medical information, such as past PSA results, current medications and active medical problems. He did not do that.

To the extent Dr. Osei-Tutu means to argue that he omitted the necessary information because Dr. Klotkin already had all of it, the evidence does not support such an argument. To the contrary, the evidence establishes that Dr. Osei-Tutu did not send the information because it was his practice not to unless it was requested. See, e.g., Tr. I, p. 115. I also note that Dr. Klotkin did not have Patient A's medical records from the prison, including the PSA test results from October 2002 or March 2003.

After weighing the evidence, I conclude that Dr. Osei-Tutu failed to meet the standard of care in 2003 for the average qualified internist when he neglected to provide Dr. Klotkin with pertinent medical information, including Patient A's current medications, active medical problems and previous PSA test results.

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5. <u>Failing to Advocate for an Expedited Consultation and Prostate Biopsy.</u>

When Dr. Osei-Tutu requested the urology consult in November 2003, Patient A had had an elevated PSA level for over seven months. Moreover, his PSA level had doubled in one year. Under these circumstances, the standard of care for the average qualified internist required that Dr. Osei-Tutu try to expedite the urology consultation and subsequent prostate biopsy. He did not do so.

Dr. Osei-Tutu correctly points out that he did not control Dr. Klotkin's schedule and could not mandate when the biopsy took place. That, however, is not the point. The standard of care required Dr. Osei-Tutu to reach out to Dr. Klotkin on behalf of Patient A and ask for an expedited schedule. As Dr. Knights testified:

> ... if I was his primary care physician and somehow there had been a slip of six months in moving along on this elevated PSA, I would want to get that biopsy done as soon as possible, and if it meant picking up the phone and calling the urologist and saying, "Look, I am worried about this guy. He's young. His PSA is going up drastically. Could you get him in sooner?" I would make the call.

Tr. II, pp. 260-61. Moreover, it was especially important for Dr. Osei-Tutu to make the request in this case. Because Dr. Osei-Tutu's consultation request did not include Patient A's past PSA levels, Dr. Klotkin had no way of knowing that those levels had risen dramatically in one year. Consequently, Dr. Klotkin could not evaluate the potential seriousness of Patient A's situation on his own. It therefore was particularly important for Dr. Osei-Tutu to reach out to Dr. Klotkin.

In the present case, Dr. Osei-Tutu did nothing – such as talking to Dr. Klotkin on the telephone or sending him a written request – to try to have the urology consultation and subsequent prostate biopsy scheduled quickly. As a result, Dr. Osei-Tutu failed to meet the applicable standard of care for the average qualified internist.

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6. Failing to Have an Adequate Tracking System.

The Board alleges that Dr. Osei-Tutu failed to have a system in place to track whether or not physician orders were carried out. First, this charge does not appear to be in the Statement of Allegations against Dr. Osei-Tutu. The Statement of Allegations relates solely to Dr. Osei-Tutu's care of Patient A. It does not contain any claims or allegations concerning Dr. Osei-Tutu's general practices and procedures as the Medical Director at MCI-Norfolk. Thus, I do not believe Dr. Osei-Tutu was given fair notice that this charge would be a part of the case against him.

In the event that the Statement could be read to include this charge, however, I address it here. After reviewing the record, I conclude that the Board did not present sufficient evidence to sustain this charge. The Board relies on the fact that Dr. Osei-Tutu ordered Patient A to return for a sick visit to discuss his March 2003 PSA levels, but the sick visit never took place. The Board, however, did not present evidence concerning the applicable standard of care in 2003 for tracking physician orders. Nor did the Board present evidence that Dr. Osei-Tutu was responsible for establishing a tracking system at MCI-Norfolk. Although Dr. Osei-Tutu was the Medical Director at MCI-Norfolk, many procedures and policies were set by his superiors at Correctional Medical Services. See, e.g., Tr. I, pp. 35-36. Thus, while it is troubling that Patient A did not return for the sick visit as ordered, the Board has not proven by a preponderance of the evidence that Dr. Osei-Tutu was negligent with respect to establishing and maintaining a system to track physician orders at the prison.

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Conclusion and Recommendation

For the reasons set forth above, I find that Dr. Osei-Tutu failed to meet the standard of care required of the average qualified internist in the following ways: (1) he did not tell Patient A about the results of his March 2003 PSA test in a timely fashion; (2) he failed to repeat Patient A's March 2003 PSA test in a timely fashion; (3) on five separate occasions, he failed to review pertinent medical records before treating Patient A; (4) he did not provide the consulting urologist with Patient A's relevant medical history, including his current medications, active medical problems and previous PSA levels; and (5) he did not advocate for an expedited prostate biopsy. Consequently, Dr. Osei-Tutu committed negligence on repeated occasions and therefore "is guilty of conduct which places into question [his] competence to practice medicine." G.L. c. 112, § 5(c).

I further conclude that the Board's Statement of Allegations did not include charges that Dr. Osei-Tutu (1) failed to have a system to track physician orders; or (2) committed gross negligence. Thus, those charges are not a proper part of this case.

Based on the foregoing, I recommend that the Board impose appropriate discipline on Dr. Osei-Tutu.

SO ORDERED.

DIVISION OF ADMINISTRATIVE LAW APPEALS

Natalie S. Monroe
Administrative Magistrate

Date: July 8, 2008

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