IN THE MATTER OF	*	**BEFORE THE**
MICHAEL A. BASCO, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D72935	*	**Case Numbers: 2013-0723 and 2013-0853**

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CONSENT ORDER

PROCEDURAL BACKGROUND

On January 7, 2014, the Maryland State Board of Physicians (the "Board") charged **MICHAEL A. BASCO, M.D.** (the "Respondent"), License Number D72935, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* and the Code of Maryland Regulations ("COMAR") tit. 10, § 32.12 *et seq.*

The Board charged the Respondent with violating the following provisions of the Act under H.O. § 14-404(a):

(3) Is guilty of: (ii) unprofessional conduct in the practice of medicine;

(18) Practices medicine with an unauthorized person or aids an unauthorized person in the practice of medicine;

(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; and

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

The Board also charged the Respondent with violating the following COMAR provisions:

10.32.12.04 Scope of Delegation.

E. A physician may not delegate to an assistant acts which include but are not limited to:

(1) Conducting physical examinations;

(2) Administering any form of anesthetic agent or agent of conscious sedation other than topical anesthetics or small amounts of local anesthetics;

(3) Initiating independently any form of treatment, exclusive of cardiopulmonary resuscitation;

(4) Dispensing medications; [and]

(5) Giving medical advice without the consult of a physician[.]

10.32.12.05 Prohibited Conduct.

B. A delegating physician, through either act or omission, facilitation, or otherwise enabling or forcing an assistant to practice beyond the scope of this chapter, may be subject to discipline for grounds within Health Occupations Article, § 14-404(a), Annotated Code of Maryland, including, but not limited to, practicing medicine with an unauthorized person or aiding an unauthorized person in the practice of medicine.

On February 26, 2014, Disciplinary Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this DCCR, the Respondent agreed to enter into this Consent Order, which consists of Procedural Background, Findings of Fact, Conclusions of Law, Order, Consent and Notary.

FINDINGS OF FACT

Disciplinary Panel B makes the following Findings of Fact:

A. Licensing Information

1. At all times relevant hereto, the Respondent was licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on August 17, 2011, under License Number D72935. The Respondent's license to practice medicine in the State of Maryland is currently suspended (see *infra*).

2. The Respondent is board-certified in obstetrics and gynecology.

B. Disciplinary Actions

3. On or about August 15, 2003, the Respondent entered into an Agreed Order with the Texas Board of Medical Examiners (the "Texas Board") to resolve allegations that he was subject to a peer review action for failing to completely disclose information that he submitted in a hospital privilege application. The Texas Board found as a matter of law that the Respondent was subject to discipline for (a) unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public or for (b) having been subject to discipline by his peers in a hospital, professional medical association or society. Pursuant to the terms of the Agreed Order, the Texas Board reprimanded the Respondent.

4. On or about August 26, 2011, the Respondent entered into an Agreed Order with the Texas Board to resolve allegations that he failed to record adequate documentation in a patient's medical record, in violation of a Texas Board rule that requires that a physician maintain adequate medical records. Pursuant to the terms of the Agreed Order, the Texas Board required, *inter alia*, that the Respondent enroll in and successfully complete eight credit hours of continuing medical education

coursework in medical recordkeeping and pay an administrative penalty in the amount of $3,000.00.

5. On or about August 26, 2012, the Pennsylvania Board of Medicine (the "Pennsylvania Board") issued an Adjudication and Order in which it reprimanded the Respondent for being disciplined in Texas in 2011 for failing to maintain adequate medical records.

6. On or about December 27, 2012, the Board reprimanded the Respondent for being disciplined by the Pennsylvania Board for an act or acts that would be grounds for disciplinary action under H.O. § 14-404(a)(40), had those offenses been committed in Maryland.

7. On or about May 29, 2013, the Board issued an Order for Summary Suspension pursuant to Md. State Gov't Code Ann. (S.G.") § 10-226(c)(2) in which it summarily suspended the Respondent's Maryland medical license (see ¶ 10, *infra*). The Board took such action after reviewing the Respondent's practice at Associates in OB/GYN Care ("Associates"), a medical practice that provides abortion services at offices located in Baltimore, Frederick, Cheverly and Silver Spring.

8. On or about June 20, 2013, the Medical Board of California suspended the Respondent's California medical license as a result of the Board's action.

9. On or about July 10, 2013, the District of Columbia Board of Medicine summarily suspended the Respondent's medical license in the District of Columbia as a result of the Board's action.

C. Board Order for Summary Suspension, dated May 29, 2013

10. The Board initiated an investigation of the Respondent after reviewing the Maryland Office of Health Care Quality's ("OHCQ")[1] investigation of Associates.

11. OHCQ summarily suspended the licenses of three of Associates' offices on or about March 5, 2013, for violations of the State's surgical abortion facility regulations. *See* COMAR 10.12.01.01 *et seq.*

12. OHCQ subsequently reinstated the licenses but then on or about May 9, 2013, suspended the licenses of all four of Associates' offices for continuing violations of the regulations, concluding that the deficiencies at Associates' offices placed patients at risk of serious harm or death. OHCQ ordered that Associates immediately cease providing surgical abortions, determining that the public health, safety or welfare imperatively required emergency action.

13. The Respondent provided abortion services at Associates' offices during the time of OHCQ's survey in February 2013 and was the sole physician on duty during an incident that occurred at the Baltimore office on May 4, 2013, when the OHCQ found that the facility "was not equipped to complete a procedure safely . . . failed to implement a safe discharge plan for the patient . . . [which] . . . could have resulted in serious or life-threatening harm or death to the patient."

14. After reviewing these investigative findings, the Board issued an Order for Summary Suspension against the Respondent pursuant to S.G. § 10-226(c)(2). The

[1] OHCQ is a State agency that licenses and certifies state health care facilities and monitors the quality of care in those facilities. OHCQ monitors state health care facilities under its jurisdiction for compliance with all applicable state and federal regulations.

Board concluded that the Respondent's actions constituted a substantial likelihood of risk of serious harm to the public health, safety and welfare, which imperatively requires the immediate suspension of his license to practice medicine.

15. The Board convened a show cause hearing on June 12, 2013, during which time the Respondent argued that the Board should lift the Board's Order for Summary Suspension against him. After hearing arguments from the Respondent and the assigned administrative prosecutor, the Board issued an order continuing the summary suspension.

D. OHCQ Investigation

16. OHCQ initially inspected Associates' surgical abortion facilities in February 2013, during which time it found that Associates committed numerous violations of the State's surgical abortion facility regulations. After considering these findings, the Secretary of the Department of Health and Mental Hygiene (the "Secretary") summarily suspended the licenses of Associates' Baltimore, Cheverly and Silver Spring offices, concluding that there was a threat to the public health and safety.

17. OHCQ found that Associates' Cheverly facility was in violation of COMAR 10.12.01.09 because (a) the pads of its Automated External Defibrillator ("AED") expired in 2008; (b) the clinical nurse on site did not know how to use the AED and suction machine; (c) the District Manager admitted to the surveyor that the nurses had not been trained on the use of the AED and suction machine; and (d) the suction machine did not work because an adapter was missing.

18. OHCQ found that Associates' Baltimore and Silver Spring locations violated COMAR 10.12.01.07A and B by failing to perform surgical abortion services in

a safe manner and by failing to develop appropriate post-anesthesia procedures and protocols.

19. During the survey, which occurred on February 26, 2013, OHCQ inspectors evaluated the Respondent's performance of an abortion that occurred that day at the Silver Spring office. OHCQ investigators found that the Respondent left a patient ("Patient A")[2] unattended for a period of time after he administered moderate sedation to her and inserted laminaria in her cervix in preparation for an abortion, in violation of COMAR 10.12.01.07B(4).

20. The Secretary subsequently lifted the suspensions of the clinics' licenses pending Associates' submission of acceptable written plans of correction.

21. OHCQ then received an anonymous complaint, dated May 7, 2013, regarding treatment a patient ("Patient B") received at Associates' Baltimore office on May 4, 2013, when the Respondent was scheduled to perform surgical abortions there.

22. The Respondent previously instructed the staff at Associates to give patients who were seeking pregnancy terminations the drug misoprostol, a medication that is used to induce or facilitate abortions, if the staff determined through ultrasound that the patients' pregnancy length was at least eleven weeks in duration.

23. The complaint stated that Patient B presented to Associates' Baltimore office on May 4, 2013, for a scheduled appointment for an abortion. At the time, no physician was on site.

24. An Associates employee asked the Patient to complete the initial paperwork. The same employee, who holds no health care license, certification, or

[2] For confidentiality purposes, the names of patients or other individuals have not been disclosed in this Consent Order. The Respondent is aware of the identities of all individuals referenced herein.

formal training or certification in sonography, then performed an ultrasound on Patient B that revealed multiple gestations. The employee asked Patient B to sign a form giving consent for a surgical abortion and for the administration of misoprostol. The employee administered the misoprostol to Patient B when no physician was present in the facility and before any physician or licensed health care professional had any contact with Patient B.

25. The Respondent then arrived at the office, declined to perform the surgical abortion and attended to other matters, during which time Patient B reportedly sat in the waiting room, awaiting further medical attention.

26. After an extended period of time, the Respondent contacted Patient B by cell phone and discovered that she was still in the office. He then verbally offered Patient B three options: (a) she could travel in two days to Associates' Frederick office for the administration of laminaria and additional misoprostol, with follow-up the following day in Associates' Baltimore facility for a dilatation and curettage ("D & C") and follow-up the day after that in Associates' Cheverly or Silver Spring office for a second D & C, if needed; (b) an Associates employee could transport her to a site in New Jersey where a surgical abortion could be performed while she was under general anesthesia; or (c) the Respondent could attempt to identify a local hospital that could complete a surgical abortion procedure.

27. Patient B then left the facility. The Respondent and Associates staff provided no written discharge instructions to Patient B. The Respondent did not accurately describe in Patient B's medical record what occurred and what was

discussed with Patient B during the encounter. In addition, the Respondent did not provide adequate written discharge instructions to Patient B.

28. Later that day, Patient B presented to another facility that was not associated with Associates. While there, Patient B reportedly spontaneously aborted one of the fetuses, whereupon facility staff performed surgical abortions of Patient B's remaining fetuses.

29. The Respondent practiced at facilities in which unlicensed/unqualified office staff was allowed to perform ultrasounds, evaluate fetal gestational age, and provide medications to patients to promote abortions. Associates' staff admitted to OHCQ surveyors that Associates' standard protocol was to administer misoprostol to all patients at 11 weeks' gestation or beyond, even if the patient had not been evaluated by a physician, and even if no physician was available on site.

30. OHCQ investigation determined that Associates initiated a surgical abortion in a facility that was not equipped to complete the procedure safely. In addition, Associates failed to implement a safe discharge plan for Patient B. OHCQ concluded that these deficiencies constituted violations of COMAR 10.12.01.07A and 10.12.01.01A, which could have resulted in serious or life-threatening harm or death to the Patient.

31. On June 5, 2013, OHCQ filed a Notice of Intent to Revoke Surgical Abortion Facility Licenses against all four of Associates' clinic locations.

E. Basis of Violations

32. The Respondent provided abortion services at Associates during which time its offices violated numerous provisions of the State's surgical abortion facility

regulations that could have resulted in serious or life-threatening harm of death to patients. The Respondent continued to provide abortion services at Associates that were not in compliance with the State's surgical abortion facility regulations. In addition, the Respondent did not provide Patient B with appropriate written discharge instructions.

33. The Respondent practiced medicine at Associates with an unauthorized person or persons and aided an unauthorized person or persons in the practice of medicine there, in violation of the following provision of the Act: practicing medicine with an unauthorized person or aiding an unauthorized person in the practice of medicine, in violation of H.O. § 14-404(a)(18). The Respondent provided abortion services in which he permitted, instructed or allowed one or more of Associates' staff to practice medicine, which included performing physical examinations, including sonograms, dispensing/providing medications, independently initiating a form of treatment, and giving medical advice. In addition, the Respondent permitted, instructed or allowed one or more of Associates' staff to perform non-delegable tasks in his absence, including performing physical examinations, initiating independently a form of treatment, dispensing/providing medications, and giving medical advice, in violation of COMAR 10.32.12.04 and 10.32.12.05.

34. The Board obtained medical records involving six patients to whom the Respondent provided abortion services at Associates. The Board referred these records and other associated investigative materials to two board-certified obstetrician-gynecologists for peer review.

35. The reviewers agreed that the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care with respect to Patients A and B and failed to keep adequate medical records in the case of Patient B.

36. With respect to Patient A, the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care, in violation of H.O. § 14-404(a)(22), in that on or about February 26, 2013, he inappropriately left Patient A unattended/unsupervised for a period of time after he administered moderate sedation during the performance of a medical procedure.

37. With respect to Patient B, the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care, in violation of H.O. § 14-404(a)(22), in that on or about May 4, 2013, he (a) inappropriately permitted unlicensed medical assistants to administer misoprostol prior to personally confirming fetal gestational age and before concluding that the procedure was appropriate; (b) inappropriately discharged Patient B after misoprostol administration; (c) provided inappropriate counseling to Patient B; and (d) failed to provide written discharge instructions.

38. With respect to Patient B, the Respondent failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), in that he failed to record adequate documentation regarding: (a) the administration of misoprostol and the circumstances surrounding the administration of misoprostol; (b) his discharge of Patient B; (c) the discharge instructions he provided to Patient B; and (D) his medical decision-making after Patient B was administered misoprostol and he discharged her without performing a pregnancy termination.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Disciplinary Panel B concludes as a matter of law that the Respondent violated the following provisions of the Act: H.O. § 14-404(a)(18), Practices medicine with an unauthorized person or aids an unauthorized person in the practice of medicine; 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 in this State; and H.O. § 14-404(a)(40), Fails to keep adequate medical records as determined by appropriate peer review. Disciplinary Panel B also concludes as a matter of law that the Respondent violated the following COMAR provisions: 10.32.12.04 and 10.32.12.05.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is hereby

ORDERED that the Order for Summary Suspension, dated May 29, 2013, is hereby **TERMINATED**; and it is further

ORDERED that the Respondent's license to practice medicine in the State of Maryland is hereby **SUSPENDED** for **NINE (9) MONTHS,** effective May 29, 2013; and it is further

ORDERED that after the conclusion of the entire **NINE (9) MONTH SUSPENSION** imposed above, Disciplinary Panel B will lift the suspension and the Respondent will be placed on **PROBATION** for a minimum period of **EIGHTEEN (18) MONTHS,** to commence on the date Disciplinary Panel B lifts the **SUSPENSION**, and continuing until he successfully completes the following probationary terms and conditions:

1. The Respondent shall not delegate any acts in violation of COMAR 10.32.12.04E (2013) to a medical assistant or other non-qualified personnel in any health care facility where he practices or has privileges;

2. The Respondent shall not have any professional association or relationship with, or provide any medical/surgical services on behalf of, American Women's Services or any health care entity or facility that has a direct or indirect relationship with Steven C. Brigham, M.D.;

3. Within six (6) months of the date Disciplinary Panel B executes this Consent Order, the Respondent shall successfully complete a Disciplinary Panel B-approved course in medical recordkeeping. The Respondent shall submit written documentation to Disciplinary Panel B regarding the particular course he proposes to fulfill this condition. Disciplinary Panel B reserves the right to require the Respondent to provide further information regarding the course he proposes, and further reserves the right to reject his proposed course and require submission of an alternative proposal. Disciplinary Panel B will approve a course only if it deems the curriculum and the duration of the course adequate to satisfy its concerns. The Respondent shall be responsible for submitting written documentation to Disciplinary Panel B of his successful completion of this course. The Respondent understands and agrees that he may not use this coursework to fulfill any requirements mandated for licensure renewal. The Respondent shall be solely responsible for furnishing Disciplinary Panel B with adequate written verification that he has completed the course according to the terms set forth herein; and

4. The Respondent shall comply with the Act and all laws, statutes and regulations pertaining to the practice of medicine.

AND IT IS FURTHER ORDERED that the charge that the Respondent violated H.O. § 14-404(a)(3), Is guilty of: (ii) Unprofessional conduct in the practice of medicine, is hereby **DISMISSED**; and it is further

ORDERED that after the conclusion of the entire **EIGHTEEN (18) MONTH** period of **PROBATION,** the Respondent may file a written petition to Disciplinary Panel B requesting termination of his probation. After consideration of his petition, the probation may be terminated through an order of Disciplinary Panel B or a designated Disciplinary Panel B committee. The Respondent may be required to appear before Disciplinary Panel B or a designated Disciplinary Panel B committee. Disciplinary Panel B, or a designated Disciplinary Panel B committee, will grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions of this Consent Order, including the expiration of the eighteen (18) month period of probation, and if there are no outstanding complaints related to the charges before the Board or Board panel; and it is further

ORDERED that if the Respondent violates any of the terms or conditions of this Consent Order or of probation, Disciplinary Panel B, in its discretion, after notice and an opportunity for a 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 Disciplinary Panel B, may impose any other disciplinary sanctions Disciplinary Panel B may have imposed, including a

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

ORDERED that the Respondent shall not apply for early termination of probation; 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 is considered a **PUBLIC DOCUMENT** pursuant to Md. State Gov't. Code Ann. § 10-611 *et seq.* (2009 Repl. Vol. and 2013 Supp.).

2/28/2014
Date

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

CONSENT

I, Michael A. Basco, M.D., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

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 as provided by law. I acknowledge the legal authority and the jurisdiction of Disciplinary Panel B to initiate these proceedings and to issue and enforce this Consent Order. I also affirm that I am

waiving my right to appeal any adverse ruling of Disciplinary Panel A that might have followed any such hearing.

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

02/27/2014
Date

Michael A. Basco, M.D.
Respondent

Read and approved by:

Thomas L. Doran, Esquire
Counsel for Dr. Basco

NOTARY

STATE OF Maryland

CITY/COUNTY OF: Prince Georges

I HEREBY CERTIFY that on this 27th day of February 2014, before me, a Notary Public of the State and County aforesaid, personally appeared Michael A. Basco, M.D., 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.

Lynda Christine Cuevas
Notary Public

My commission expires: 4/16/2014