

IN THE MATTER OF

*

BEFORE THE MARYLAND

**MEHRDAD AALAI, M.D.,
License No. D26712**

*

STATE BOARD OF

Respondent.

PHYSICIANS

Case No. 2008-0347

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FINAL DECISION AND ORDER

I. Procedural History

On July 27, 2010, the Maryland State Board of Physicians (the "Board") charged Mehrdad Aalai, M.D., an obstetrician-gynecologist who at all times relevant to this matter, practiced in College Park, Maryland, with immoral or unprofessional conduct in the practice of medicine, abandonment of a patient, failure to meet appropriate standards for the delivery of quality medical care, and failure to keep adequate medical records in violation of sections 14-404(a)(3), (6), (22), and (40) of the Health Occupations Article of the Maryland Annotated Code.

Those sections provide as follows:

(a) Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

- (3) Is guilty of:
 - (i) Immoral conduct in the practice of medicine; or
 - (ii) Unprofessional conduct in the practice of medicine;

* * * * *

- (6) Abandons a patient;
- * * * * *

- (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State;

* * * *

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

Md. Code Ann., Health Occ. §§ 14-404(a)(3), (6), (22), (40) (Supp. 2011).

The State decided not to pursue the charge of abandoning a patient. The remaining charges were heard by an Administrative Law Judge (“ALJ”) on May 18 and 19, 2011, at the Office of Administrative Hearings in Hunt Valley, Maryland. The Administrative Prosecutor submitted twenty-two exhibits, all of which were admitted, and presented the testimony of Nathan Berger, M.D., an expert in the field of obstetrics and gynecology; Stephanie Lester-Simmonds, M.D., an obstetrician-gynecologist at Potomac Hospital in Virginia; Victoria McIntyre, Compliance Analyst for the Board; and Maureen Holste, the mother of Patient A.¹ Dr. Aalai submitted seven exhibits, all of which were admitted, and testified on his own behalf and as an expert in obstetrics and gynecology.²

The ALJ issued her proposed decision on August 16, 2011, a copy of which is attached to this Final Opinion and Order as Attachment A. The ALJ concluded that Dr. Aalai violated the Maryland Medical Practice Act and recommended that his license be revoked.

Dr. Aalai submitted exceptions to the Board, and the Administrative Prosecutor responded. The Board held a hearing on the exceptions on November 16, 2011. This Final

¹ To protect the confidentiality of her identity, the patient whose care gave rise to these charges is referred to as Patient A.

² A complete list of the exhibits is contained in the ALJ’s proposed decision at pages 2 through 3.

Opinion and Order is the Board's final ruling on the case after considering the record, the written exceptions filed by Dr. Aalai, and the oral arguments at the Exceptions Hearing.

II. Findings of Fact

The Board adopts the Findings of Fact made by the ALJ at pages 4 through 9 of Attachment A and incorporates them by reference into this Final Opinion and Order.

III. Conclusions of Law

The Board adopts the conclusions of law discussed by the ALJ on pages 10 through 18 of Attachment A and incorporates them by reference into this Final Opinion and Order.

IV. The Respondent's Exceptions

Dr. Aalai raised several exceptions to the ALJ's proposed decision. After careful consideration of the parties' written submissions and the argument at the hearing, all of the exceptions are overruled.

A. The ALJ properly exercised her discretion in admitting State Exhibit No. 22.

Dr. Aalai objected to the admission of State's Exhibit No. 22, a newsletter article about proper medical recordkeeping, because it was not produced before the prehearing conference. The ALJ overruled the objection because her order explicitly allowed the exchange of additional exhibits before the hearing, and Dr. Aalai's counsel acknowledged that he had received the newsletter more than two weeks before the hearing. Transcript at 27-28. Under these circumstances, the ALJ did not abuse her discretion in admitting State's Exhibit No. 22. *See Solomon v. State Board of Physician Quality Assurance*, 155 Md. App. 687, 705 (2003) (ALJ's evidentiary rulings reviewed for abuse of discretion); Md. Code Ann., State Gov't § 10-213(g) (ALJ may admit documents into evidence).

B. The ALJ properly overruled objections regarding the testimony of Dr. Lester-Simmonds.

Dr. Lester-Simmonds, the physician who treated Patient A at Potomac Hospital in Virginia, testified about patient A's condition when she arrived at the hospital and the treatment that Patient A received at the hospital. *See* Transcript at 74-90. Dr. Aalai objected to two questions that the Administrative Prosecutor asked because, he claimed, the questions called for expert testimony and the State had not identified Dr. Lester-Simmonds as an expert witness expected to testify at the hearing. The ALJ properly overruled those objections.

The rules governing the hearing before the ALJ in this matter have two requirements regarding witnesses: COMAR 10.32.02.03E(3)(a) requires a party to produce a list of witnesses to be called at the hearing within fifteen days of a written request from another party, and COMAR 10.32.02.03E(4)(a) requires a party to provide the name and curriculum vita of any expert witness who will testify at the hearing as well as a detailed written report from each witness. The State identified Dr. Lester-Simmonds as a witness, but not as an expert witness.

Undoubtedly, Dr. Lester-Simmonds is an expert: Her testimony as Patient A's treating physician was based on her specialized education and training and her expertise as a physician. *See State v. Blackwell*, 408 Md. 677, 693 (quoting DAVID H. KAYE, *THE NEW WIGMORE: EXPERT EVIDENCE*, § 3.2.1 (2004)). That conclusion, however, does not end the matter.

In *Dorsey v. Nold*, 362 Md. 241 (2001), the court distinguished between experts specially retained for the purpose of testifying at a trial and those persons who may be experts, but whose opinions were not developed for purposes of litigation. A physician who performed an autopsy and reached a conclusion about the cause of death as part of the performance of his duty as medical examiner was an expert witness, but not one whose opinion was developed for the

litigation. *Id.* at 257-59. Thus, under the 2001 version of the Maryland Rules, the medical examiner's identity and opinions did not have to be disclosed as an expert witness expected to testify at trial.³

The Board concludes that its procedural rules should be construed to draw a similar distinction as that drawn in the *Dorsey* case: The parties do not have to provide the information required by COMAR 10.32.02.03E(4) for witnesses like Dr. Lester-Simmonds who are called for the purpose of testifying about the events giving rise to the charges in a particular case and their involvement in those events. Thus, the ALJ properly overruled Dr. Aalai's objections claiming that the State had not complied with COMAR 10.32.02.03E(4).

Even if the questions were in some way objectionable, the medical answers to these questions are obvious to the Board. The Board has the authority to use its specialized knowledge in the evaluation of the evidence, *see* Md. Code Ann., State Gov't § 10-213(i), and would have known the information supplied in the answers given by Dr. Lester-Simmonds. Accordingly, although there was no error committed by the ALJ, any such error, had it occurred, would have been harmless.⁴

C. There is no requirement that a failure to keep adequate medical records affect a patient's care to constitute a violation of the Maryland Medical Practice Act.

Section 14-404(a)(40) of the Health Occupations Article authorizes the Board to discipline a licensee who “[f]ails to keep adequate medical records as determined by appropriate

³ After the decision in *Dorsey v. Nold*, the Court of Appeals amended the Maryland Rules to require disclosures of all experts expected to testify at trial, not simply those retained for the purpose of testifying at trial. *See* Committee note, Md. Rule 2-402(g)(1)(A).

⁴ Furthermore, the Board notes that the ALJ did not rely on any of Dr. Lester-Simmonds' testimony in reaching her conclusions that Dr. Aalai's treatment of Patient A violated the Maryland Medical Practice Act.

peer review.” Md. Code Ann., Health Occ. § 14-404(a)(40). The statute does not require that the inadequate record keeping affect the care provided by the licensee. Generally, in construing statutes, courts “apply the language as written and in a commonsense manner. [Courts] do not add words” *Downes v. Downes*, 388 Md. 561, 571 (2005). Thus, the Board declines Dr. Aalai’s invitation to add to the language in section 14-404(a)(40) and overrules his exception based on the argument that his admittedly poor record keeping did not affect the care that he provided to Patient A.

D. The remaining exceptions are overruled.

Dr. Aalai’s remaining exceptions ask the Board to reevaluate the evidence and reach conclusions different from those reached by the ALJ. The Board declines to do so. Based on its review of the record, it reached the same conclusions as the ALJ.

V. Sanction and Order

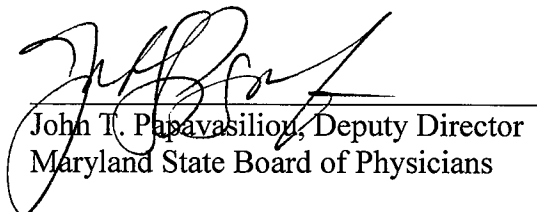
Based on the above Findings of Fact and Conclusions of Law, it is hereby **ORDERED** as follows:

1. Dr. Aalai shall be suspended for six months from the date of this Order, with the final three months stayed;
2. Dr. Aalai is placed on probation for a period of two years, beginning three months from the date of this Order and subject to the conditions set out in paragraphs 3 and 4, below;
3. Dr. Aalai shall complete courses in the proper handling of obstetrical emergencies and medical record documentation, such courses to be approved in advance in writing by the Board and not to be counted toward

the normal Continuing Medical Education credits required of all physicians as a condition of continued licensure;

4. During the period of probation, the Board shall have the discretion to conduct a peer review and/or a practice review of Dr. Aalai's practice;
5. Dr. Aalai shall comply with all laws governing the practice of medicine under the Maryland Medical Practice Act and all rules and regulations promulgated thereunder;
6. Dr. Aalai shall be responsible for all costs incurred in fulfilling the terms and conditions of this order;
7. If Dr. Aalai violates any of the conditions of probation or of this Order, the Board may impose any sanction which the Board may have imposed in this case under Health Occ., §§ 14-404(a) and 14-405.1 of the Medical Practice Act, including additional probation, a reprimand, additional suspension, revocation and/or a monetary fine;
8. Dr. Aalai shall not petition the Board for early termination of his probation or any of the terms of probation, or early commencement of the stay; and
9. This Final Decision and Order is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 et seq. (2009).

SO ORDERED this 28th day of December, 2011.


John T. Papavasiliou, Deputy Director
Maryland State Board of Physicians

NOTICE OF RIGHT TO APPEAL

Pursuant to Maryland Health Occ. Code Ann. § 14-408(b), Dr. Aalai has the right to seek judicial review of this decision. Any petition for judicial review shall be filed within 30 days from the receipt of this Final Order and shall be made as provided for judicial review of a final decision in the Maryland Administrative Procedure Act, State Gov't Article § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Dr. Aalai files an appeal, the Board is a party and should be served with the court's process at the following address:

Maryland State Board of Physicians

c/o Thomas W. Keech, Assistant Attorney General

Department of Health and Mental Hygiene

300 West Preston Street, Suite 302

Baltimore, Maryland 21201

STATE BOARD OF PHYSICIANS

v.

MEHRDAD AALAI, M.D.

License No. D26712

RESPONDENT

* BEFORE YOLANDA L. CURTIN,
* AN ADMINISTRATIVE LAW JUDGE
* OF THE MARYLAND OFFICE
* OF ADMINISTRATIVE HEARINGS
* OAH NO.: DHMH-SBP-71-11-10524

* * * * *

PROPOSED DECISION

STATEMENT OF THE CASE
ISSUES
SUMMARY OF THE EVIDENCE
FINDINGS OF FACT
DISCUSSION
CONCLUSIONS OF LAW
PROPOSED ORDER

STATEMENT OF THE CASE

On July 27, 2010, the Maryland State Board of Physicians (Board) issued charges against Mehrdad Aalai (Respondent) for immoral or unprofessional conduct in the practice of medicine, abandonment of a patient, failure to meet appropriate standards for the delivery of quality medical care and for failing to keep adequate medical records in violation of the Medical Practice Act. Md. Code Ann., Health Occ. §§ 14-404(a)(3), (6), (22) and (40) (Supp. 2010). The Board forwarded the charges to the Office of the Attorney General (State) for prosecution.

A Pre-Hearing Conference in this matter was held on April 7, 2011, at the Office of Administrative Hearings (OAH). Thereafter, I held a hearing on May 18 and 19, 2011, at the OAH. Hunt Valley, Maryland. Md. Code Ann., Health Occ. § 14-405(a) (2009). Throughout these proceedings, Dawn L. Rubin, Assistant Attorney General, represented the State. Marc K. Cohen, e, and Ian I. Friedman, Esquire, represented the Respondent.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules of Procedure for the Board, and the Rules of Procedure of OAH. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2009 & Supp. 2010); Code of Maryland Regulations (COMAR) 10.32.02; COMAR 28.02.01.

ISSUES¹

Did the Respondent in his treatment of Patient A² engage in any of the following: immoral or unprofessional conduct in the practice of medicine, failure to meet appropriate standards of care and/or failure to keep adequate medical records in violation of Md. Code Ann., Health Occ. §§ 14-404(a)(3)(i) and (ii), (22) and (40), respectively; and if so, what is the appropriate sanction?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following exhibits on behalf of the State:

- State Ex. 1 - July 27, 2010 Notice of Charges and Charges Under the Medical Practice Act
- State Ex. 2 - Certificate of Service
- State Ex. 3 - Initial Application for Licensure
- State Ex. 4 - Renewal Application
- State Ex. 5 - Complaint
- State Ex. 6 - October 6, 2008 letter from Board to Respondent, with attachment
- State Ex. 7 - October 20, 2008 letter from Board to Respondent
- State Ex. 8 - Transcript of Respondent's interview
- State Ex. 9 - December 19, 2007 Memorandum of Stephanie Lester Simmonds telephone

¹ The Respondent was also charged with abandoning a patient under Md. Code Ann., Health Occ. § 14-404(a)(6); however, at the hearing, the State advised that it would not pursue the charge.

² To protect the confidentiality of her identity, the patient will be referred to as "Patient A."

interview

- State Ex. 10 - December 31, 2007 Memorandum of Maureen Holste telephone interview
- State Ex. 11 - January 11, 2008 Memorandum of Patient A interview
- State Ex. 12 - January 11, 2008 Memorandum
- State Ex. 13 - Report of Investigation
- State Ex. 14 - Medical records received from Respondent
- State Ex. 15 - Medical records from Potomac Hospital
- State Ex. 16 - Peer Review Referral Form
- State Ex. 17 - Peer Review Report by Dr. Charles Greenhouse, with attachment
- State Ex. 18 - Peer Review Report by Dr. Nathan Berger, with attachment
- State Ex. 19 - Final Order and Opinion in MBP Case #94-0357
- State Ex. 20 - Order of Reinstatement in MBP Case #94-0357
- State Ex. 21 - Termination of Probation in MBP Case #94-0357
- State Ex. 22 - June 1996 BPQA Newsletter article

I admitted the following exhibits on behalf of the Respondent:

- Resp. Ex. 1 - Curriculum Vitae for Dr. Siamack Bahrami
- Resp. Ex. 2 - Report of Dr. Siamack Bahrami
- Resp. Ex. 3 - Respondent's Curriculum Vitae
- Resp. Ex. 4 - Respondent's Report
- Resp. Ex. 5 - January 2, 2008 letter from Victoria McIntyre to Maureen Holste, with attachment
- Resp. Ex. 6 - January 17, 2008 letter from Victoria McIntyre to Patient A, with attachment
- Resp. Ex. 7 - September 29, 2009 letter from Victoria McIntyre to Patient A, with attachment

Testimony

The State called the following witnesses:

1. Dr. Nathan Berger, accepted as an expert in the field of obstetrics and gynecology (OB/GYN)
2. Dr. Stephanie Lester-Simmonds, OB/GYN physician at Potomac Hospital
3. Victoria McIntyre, Board Compliance Analyst
4. Maureen Holste, Patient A's mother

The Respondent testified on his own behalf and he was accepted as an expert in OB/GYN. He did not call any other witnesses.

FINDINGS OF FACT

I find the following facts by a preponderance of the evidence³:

1. At all times relevant to this matter, the Respondent was and is licensed to practice medicine in the State of Maryland, under license number D26712. He was initially licensed on or about July 29, 1981, and his license is presently active.
2. At all times relevant to this matter, the Respondent was a physician engaged in the practice of OB/GYN at American Women's Services, 4700 Berwyn House Road, Suite 203, College Park, Maryland 20740. The Respondent does not presently hold hospital privileges.
3. The Respondent practices OB/GYN.
4. The Respondent no longer works for American Women's Services.
5. At all times relevant to this matter Patient A was a resident of Virginia and she was a twenty-nine-year old female. (State Ex. 14 at MA10023).
6. As of October 2007, Patient A's medical history included five prior pregnancies. Three of those pregnancies resulted in the birth of her three children by cesarean section. The other two pregnancies resulted in miscarriages, with one of the miscarriages having occurred at thirty-one weeks. (*Id.*).
7. In October 2007 Patient A was in the second trimester of her sixth pregnancy, which she sought to terminate. She had visited a clinic in Virginia Beach to have the termination procedure performed but she was informed at that clinic that late-term terminations could not be performed

³ The parties stipulated to findings ##1-4.

- in Virginia and she was advised to seek medical assistance in Maryland. (T.⁴ Maureen Holste).
8. Patient A, along with her mother, Maureen Holste, and Patient A's infant son, traveled to American Women's Services Clinic (the Clinic) in College Park to have the procedure performed. (T. Holste).
 9. The Clinic is approximately four hours from Patient A's home in Virginia. (T. Holste).
 10. On October 23, 2007, Patient A was seen at the Clinic to commence the termination procedure. (State Ex. 14; T. Dr. Nathan Berger).
 11. The Respondent provided medical services to Patient A while she was at the Clinic and he performed the termination procedure on Patient A. (*Id.*; T. Respondent).
 12. When Patient A was first seen at the Clinic she was presented with several forms to sign, which she did, before the procedure could commence. The forms were: Consent for Laminaria Insertion, Consent for Misoprostol Prior to Surgical Abortions, Informed Consent Agreement for Non-Surgical Abortion after 14 weeks, Consent for Abortion, and Consent for Conscious Sedation. (State Ex. 14 at MA10014 - MA10019 and MA10027 - MA 10028).
 13. Laminaria is used to dilate the cervix. Misoprostol (Cytotec) is used to soften or ripen the cervix and it also encourages uterine contractions and separation of the placenta to facilitate the termination of a pregnancy. (T. Dr. Berger).
 14. There are two ways to proceed with doing a termination of pregnancy. One is to encourage the patient to go into labor, which would cause the patient to terminate the pregnancy by delivery. The second method would be to dilate the cervix and then the physician would remove the fetus and the placenta by suctioning or other methods. With both of these procedures, Laminaria is used to dilate the cervix. (T. Dr. Berger).
 15. On October 23, 2007, an ultrasound was performed on Patient A, which revealed that she was twenty-one weeks and four days pregnant. (T. Dr. Berger; State Ex. 14 at MA10020).
 16. After the ultrasound, the Respondent inserted nine Laminaria into Patient A's vagina to dilate her cervix. The Respondent did not record on Patient A's medical record the precise time of when the Laminaria was inserted. (T. Dr. Berger; MA Ex. 14 at MA10026).
 17. On October 23, 2007, Patient A was given some form of anesthesia, circled as "twilight" on Patient A's medical record when the Laminaria was inserted. The Respondent did not document on Patient A's medical record the exact medication or combination of medications that was used for the sedation or the time the anesthesia was administered. (*Id.*)
 18. After the Laminaria was inserted, the Respondent gave Patient A an antibiotic (doxycycline) and he told Patient A to return the next day. (*Id.*).

⁴ "T." refers to testimony presented at the hearing.

19. Patient A left the Clinic and stayed at a nearby hotel with her mother and infant son. (T. M. Holste).
20. On October 24, 2007, Patient A returned to the Clinic. At this time, the Respondent removed the nine Laminaria and inserted twelve additional Laminaria. Patient A was given twilight again for anesthesia. The Respondent did not record on Patient A's medical record the exact medication or combination of medications that was used for the sedation or the time the anesthesia was administered. (T. Dr. Berger; State Ex. 14 at MA10025).
21. Patient A's medical record for October 24, 2007, indicated that her membranes had ruptured, but there was no notation to explain how this occurred, either spontaneously or mechanically or when it occurred. (*Id.*).
22. During pregnancy, once membranes rupture, there is no longer a physical membranous barrier between the intrauterine pregnancy and the vaginal bacteria floor, which means that a patient is at greater risk for developing infection. Once the membranes rupture, a physician can develop a time frame to determine when the termination procedure should take place in order to avoid the risk of infection. (T. Dr. Berger).
23. On October 24, 2007, the Respondent did not perform the termination procedure. He told Patient A to return the next day and he gave her two Cytotecs to take in the morning before her return to the Clinic. Patient A left the clinic and stayed again at the hotel with her mother and infant son. (T. Dr. Berger; State Ex. 14 at MA10025; T. M. Holste).
24. Patient A returned to the Clinic on October 25, 2007 between 10:00 a.m. and 11:00 a.m. At 1:20 p.m. the Respondent removed the twelve Laminaria he had inserted the previous day and he noted on the patient's medical record that she was not ready.⁵ He gave the patient additional Cytotec and he had her wait at the Clinic until she was ready for the procedure. (*Id.*).
25. While at the Clinic Patient A started to have contractions and she experienced vaginal bleeding. At some point, the Respondent reexamined Patient A and determined that she was ready for the procedure. (T. M. Holste; State Ex. 11; T. Respondent).
26. On October 25, 2007, the Respondent performed a nonsurgical pregnancy termination procedure on Patient A. She was given conscious IV sedation (midazolam) and pain management narcotic (fentanyl) during the procedure. The Respondent was able to remove the fetus, but was unable to remove the placenta. During the procedure Patient A had many blood clots, which resulted in Patient A losing blood. (T. Dr. Berger; State Ex. 14 at MA 10029).
27. The Respondent used adjunctive measures to deliver the fetus and in his attempts to deliver the placenta. Those measures were: obstetrical maneuvers; sharp curettage of the endometrium; vacuum⁶ aspiration of amniotic fluid, blood, placenta, or products of conception; CNS decompression using a 6 mm vacurette; and uterine massage. (State Ex. 14 at MA10029; T. Dr. Berger).

⁵ The Respondent included this notation on the medical record generated for the previous day, October 24, 2007.

⁶ Also is referred to as "suction."

28. The Respondent failed to record the following information on Patient A's medical record for October 25, 2007: the time the termination procedure was performed or when it ended; the patient's vital signs, including documentation regarding pulse oximetry; any monitoring regarding IV sedation or pain management; the time the fetus was delivered, the weight of the fetus, and the estimated gestation; estimated blood loss the patient experienced; and ultrasound examination. (*Id.*).
29. The Respondent told Patient A and her mother that he could not remove the placenta and that she possibly had placenta accreta. He told them that Patient A may need to go to another doctor or hospital to have the placenta removed. At no time did he tell Patient A or her mother that the situation involved emergency action or that it was life-threatening. (T. M. Holste; State Ex. 11).
30. The placenta is the afterbirth that is a disk-type structure that is normally loosely attached to the uterine lining and will typically shed soon after delivery of a baby or termination of a pregnancy. Placenta accreta occurs when the placenta firmly attaches to the muscular part of the uterine wall. Placenta accreta requires surgical intervention. Once the placenta is dislodged a patient will experience extensive bleeding. (T. Dr. Berger).
31. After a pregnancy, the uterus empties all products of conception. If this does not occur, then material is left in the uterus that will decay and can result in potential infection that can cause a patient to develop sepsis, which is life threatening. Also ongoing bleeding will occur until the products of conception are dislodged. (*Id.*).
32. The acceptable standard of quality care when dealing with a patient who has retained the placenta requires two approaches. First, a physician may allow for more time for the placenta to dislodge, including giving the patient medication to facilitate the process. Second, if there is a concern that the placenta is attached to the uterine wall, imaging studies, such as an MRI, are done to confirm if the condition is placenta accreta, and if the patient does have placenta accreta then abdominal surgery is performed to remove the placenta or the uterus. (*Id.*; State Ex. 18).
33. Patient A was discharged from the Clinic on October 25, 2007. Her procedure lasted into the late hours of the evening and at the time she was discharged she, her mother, her infant son, the Respondent and a staff member were the only persons at the Clinic. (T. M. Holste).
34. Patient A was discharged from the Clinic with the placenta still in her uterus. (T. M. Holste; State Ex. 14 at MA10030; T. Dr. Stephanie Lester-Simmonds; T. Respondent).
35. The Respondent did not record on Patient A's medical records that he had performed any blood work to determine the amount of blood loss the patient suffered or that he did not have any imaging studies to determine if the placenta was actually attached to the uterus. (State Ex. 14; T. Dr. Berger).
36. After the Respondent told Patient A that he could not remove the placenta, Patient A informed the Respondent that she did not want to be seen by another doctor or hospital in Maryland. She told the Respondent that she wanted to return home to Virginia and follow-up with her doctor. The Respondent told Patient A and her mother that they could return to Virginia and be seen by

a doctor there. He did provide Patient A's mother with the name and address of two local Maryland hospitals. (T. M. Holste; T. Respondent).

37. Patient A was not given any written discharge instructions. The only written documentation she received from the Respondent was a document entitled "Laminaria Insertion Instructions." On this document, the Respondent hand wrote his telephone number. (T. M. Holste; T. Respondent; State Ex. 15B).
38. Patient A, her mother and infant son, left the Clinic and began to drive back to Virginia. During the ride home, Patient A sat in the passenger seat and her mother drove the vehicle. At some point Patient A fell asleep and her mother reached over and touched her to get her attention. When she touched Patient A she felt that Patient A was wet. Upon turning the car interior light on to discover the source of the wetness, she discovered that Patient A had been bleeding extensively and there was blood everywhere. (T. M. Holste).
39. Upon seeing the blood, Patient A's mother pulled off to the nearest gas station and she woke up Patient A and told her to go to the bathroom. Patient A did so, but when she took too long to return to the car, her mother went into the bathroom to get her and discovered that Patient A was slumped over a toilet, she was non-responsive and there was blood everywhere. Her mother immediately contacted 911 for assistance. (*Id.*)
40. When paramedics first arrived upon the scene they did not want to personally remove Patient A from the bathroom because they believed that Patient A had performed a termination of pregnancy in the bathroom in light of all the blood that was observed in the bathroom. After police responded to the scene and spoke with Patient A's mother the paramedics removed Patient A from the bathroom and transported her to a nearby hospital. (*Id.*).
41. Patient A was transported to the emergency room at Potomac Hospital (Potomac) and she was admitted at approximately 11:53 p.m. on October 25, 2007. Potomac is approximately an hour and half from where the Clinic is located. (T. M. Holste; T. Dr. Lester-Simmonds).
42. While at Potomac Patient A was initially seen by an emergency room doctor and then an OB/GYN. (T. Dr. Lester-Simmonds).
43. Dr. Lester-Simmons, an OB/GYN, was Patient A's treating physician at Potomac. (*Id.*).
44. Patient A's initial emergency room evaluation at Potomac revealed that she was in hemorrhagic shock, which is usually secondary to some acute blood loss. Patient A's vital signs revealed that her pulse was elevated and her blood pressure was low. She also continued to have vaginal bleeding. Her condition was determined to be in a critical state. (*Id.*; State Ex. 15A).
45. Patient A's physical examination at Potomac revealed that she had blood clots in her vagina. An ultrasound was performed that confirmed she had tissue, fluid and blood in her uterus. Blood work showed that her hemoglobin was 10.8 and hematocrit was 30. The normal value of for hemoglobin should be between 12 and 16 and for hematocrit should be between 36 and 46. (*Id.*)

46. Dr. Lester-Simmons performed a dilation and curettage (D and C) on Patient A to remove the placenta and all products of conception. It was an uncomplicated procedure that was done by suction. (*Id.*)
47. After the D and C, additional blood work was performed on Patient A. Post-operative her hemoglobin was 7.4 and her hematocrit was 21. Subsequent blood work showed that her levels had decreased to 7.1 and 20, respectively. She was diagnosed with symptomatic anemia. (*Id.*)
48. Based on her hemoglobin and hematocrit levels, Patient A was given a transfusion and she received two units of blood. (*Id.*)
49. On October 27, 2007, Patient A was discharged from Potomac. (*Id.*)
50. Dr. Lester-Simmons filed a complaint against the Respondent with the Board because the Respondent had partially treated Patient A and due to his partial treatment she was in a critical state by the time she was admitted to Potomac. (T. Dr. Lester-Simmons).
51. After Dr. Lester-Simmons filed her complaint, the Board commenced an investigation. Compliance Analyst Victoria McIntire conducted the investigation. As part of her investigation she obtained medical records from the Respondent and Potomac, she interviewed Patient A, her mother, Dr. Lester-Simmons and the Respondent. As part of the investigation, the case was referred for peer review. (T. Victoria McIntyre).
52. The two peer reviewers were Dr. Charles Greenhouse, M.D., and Dr. Nathan Berger, M.D. Both peer reviewers are Board certified in OB/GYN, with years of practical experience as practicing OB/GYNs. Based on their review of the entire case record, both peer reviewers concluded that the Respondent's treatment of Patient A did not meet the standard of quality care and that he also failed to adequately document his treatment of Patient A. (State Ex. 17 and 18).
53. Adequate medical records must be maintained by a physician because a properly kept medical record helps a physician avoid errors in treatment. Adequate medical record documentation assists the physician in focusing attention on important symptoms and findings, and more accurate diagnoses. (State Ex. 22; T. Dr. Berger).
54. The Respondent failed to maintain adequate medical records regarding his treatment of Patient A by not recording: vital signs, specific medications administered and dosages, times for when procedures were performed and completed, time of the delivery of the fetus, weight of the fetus; blood work done to determine loss of blood, and imaging studies. (T. Dr. Berger).
55. The Respondent's license was previously revoked by the Board for Medicaid fraud, on December 6, 1994. He was reinstated on May 21, 1996 and was placed on a period of probation. He successfully completed his probationary period and his probation was terminated on September 24, 2007. (State Ex. 19, 20, 21 and 22).

DISCUSSION

I. The Applicable Law and Board Charges.

The Board may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

(3) Is guilty of:

- (i) Immoral conduct in the practice of medicine; or
- (ii) Unprofessional conduct 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;

...

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

Md. Code Ann., Health Occ. § 14-404(a)(3)(i)(ii), (22), and (40) (Supp. 2010).

The State, as the moving party, has the burden of proof by a preponderance of the evidence to demonstrate that the Respondent violated the statutory and regulatory sections at issue. Md. Code Ann., State Gov't § 10-217 (2009); Md. Code Ann. Health Occ., § 14-405(b)(2) (2009); *Comm'r of Labor and Indus. v. Bethlehem Steel Corp.*, 344 Md. 17, 34 (1996) citing *Bernstein v. Real Estate Comm'n*, 221 Md. 221, 231 (1959). See also *Schaffer v. Weast*, 546 U.S. 49, 56 - 57 (2005).

The Board charged the Respondent with violating the previously cited sections of the Maryland Medical Practice Act. As discussed further below, I find that the State has presented reliable and persuasive evidence to uphold the Board's charges.

A. The Respondent's unprofessional conduct and failure to meet appropriate standards of care.

The Board charged the Respondent with being guilty of either immoral conduct in the practice of medicine or unprofessional conduct in the practice of medicine. The State did not argue

that the Respondent's conduct was immoral; instead, it argued that the Respondent was guilty of unprofessional conduct. In addition to unprofessional conduct, the State argued that the Respondent's treatment of Patient A did not meet standards of quality medical and surgical care.

The evidence presented by the Board establishes that the Respondent's treatment of Patient A was unprofessional and he did not meet standards of quality care. The Respondent allowed the patient to leave the Clinic after he had partially performed the pregnancy termination procedure. He did not inform the patient of the urgency of her condition or that it required immediate medical attention. Instead of having the patient transported to a nearby medical facility to determine if her condition was placenta accreta, he allowed Patient A to leave the Clinic.

Dr. Berger testified as an expert in the field of OB/GYN on behalf of the State and he explained the standards of quality care that should be used when performing a termination of pregnancy. Dr. Berger is well-aware of the standards of quality care as he is Board certified in the practice of OB/GYN; he has held his license to practice medicine in Maryland for over thirty years; and he has numerous years of practical experience in the field of OB/GYN. The opinions he rendered in this matter were based on his extensive review of the entire case record. He was a very knowledgeable witness who explained in great detail why the care and treatment provided by the Respondent to Patient A violated the standards of quality care.

Dr. Berger explained that a termination of pregnancy procedure involves the removal of the fetus and the placenta, as well as all products of conception. He also explained the urgent situation that exists when products of conception are retained in the uterus and not removed or when the placenta becomes embedded in the uterine wall. As testified to by Dr. Berger, when products of conception are not removed infection can result, which can be life threatening to a patient. If a placenta is not dislodged then the standard of quality care requires a physician to monitor the patient

and allow for more time for the placenta to become dislodged or if there is a possibility that the placenta is embedded in the uterine wall, then a physician needs to confirm that the patient does have placenta accreta through an MRI and, if it is placenta accreta, then steps must be taken to have the placenta surgically removed, which typically involves a hysterectomy. If the Clinic was not a facility where this could occur, then the patient should be transported to a hospital for the procedure to occur. In this case, under no circumstances, should the patient have been allowed to leave the Clinic and travel home with the placenta still in her uterus. As testified to by Dr. Berger, if the placenta was not attached to the uterine wall then eventually the placenta would come out and once that happens extensive bleeding would have occurred.

The Respondent does not dispute the testimony of Dr. Berger regarding the life threatening situation that can result if the placenta is not removed or is attached to the uterine wall. He also does not dispute that the patient left the Clinic with the placenta still in her uterus and that at the time he believed she may have had placenta accreta. Further, he acknowledged in his testimony that the standard of quality care required that the termination of pregnancy be fully completed, which included removing the placenta. He does dispute, however, the State's claim that he had a casual approach in informing the patient about the severity of her condition and that he allowed the patient to leave the Clinic when he should have had the patient transported to a hospital when his attempts to remove the placenta were unsuccessful.

According to the Respondent, Patient A left the Clinic against his medical advice. Further, he testified that before she left he told the patient and her mother that if she started bleeding the patient had to immediately be taken to a hospital. He testified that despite his repeated requests for her to seek care at a hospital or to stay at the Clinic to see if the placenta would come out, Patient A refused to stay and insisted on going home. Thus, he testified that he was not unprofessional and he

did not violate the standard of care. I do not find the Respondent's testimony credible or supported by any of the credible and reliable evidence that was presented in this case.⁷

First, his testimony is inconsistent with the statements he made during his interview with the Board investigators. During his interview, the Respondent told the investigator that he told Patient A the following: if she was not bleeding she could wait and go to the hospital the following morning; if she started to bleed then she should go to the emergency room; and it was okay for her to leave as long as she was close to her home. See Board Ex. 8 at pages 84, 88, 90 and 91. During his interview, he also stated that the patient could wait because she was not bleeding and that the "patient was not emergency, she was placenta accreta. She is not bleeding. I mean, she is okay. She can go." *Id.* at 95. Despite these statements, he now claims that he expressed urgency to the patient and that she left the Clinic against medical advice. Also, because of the inconsistent statements he made during his interview, which give the impression that he did not inform the patient about the severity of her condition, I do not find persuasive the Respondent's handwritten notation included on State Ex. 14 at MA10030, wherein the Respondent wrote "the situation fully explained to [Patient A] and her mother they were advised to go ER."

Second, there is no indication from the medical records that he took her condition to be a serious one requiring immediate medical attention and intervention. There is no documentation in any of the medical records from the Clinic that he had taken the Patient's vital signs, drawn blood to determine the amount of blood she had lost during the termination procedure, or conducted any imaging screening to determine whether or not her condition was placenta accreta or not. Although

⁷ In support of his position, the Respondent relies on a report completed by Dr. Siamack Bahrami, a Board certified OB/GYN. In his report Dr. Bahrami concluded that the Respondent did not violate the standard of care. Dr. Bahrami did not testify at the hearing. As indicated in his report, his conclusion is based on his review of "certain records" regarding the patient and additional facts and circumstances provided by the Respondent. See Respondent Ex. 2. Unlike the detailed testimony provided by Dr. Berger, which included an explanation of what the standard of care is, Dr. Bahrami's report is simply a recitation of some facts of the case and a recitation of what the Respondent told him about his care and treatment of Patient A, which Dr. Bahrami relied on to form the basis of his conclusion. As such, I do not find Dr. Bahrami's report persuasive and I give it no weight.

he testified that he did adequately monitor the patient's condition, there is no information contained in the medical records that would support the Respondent's claim that he was aware of the severity of the patient's condition and that he advised her appropriately. Further, the records obtained by the Board are devoid of any forms reflecting the patient's acknowledgement that she was leaving the Clinic against the Respondent's medical advice. The Respondent testified that he did not have the patient sign a form indicating her consent to leave the Clinic against the Respondent's medical advice because such form is simply to protect him and not the patient. He knew that the patient was not interested in staying in the Clinic or in the State of Maryland to obtain further medical treatment and, as such, he did not feel that giving her the form to sign was in any way helpful to the patient or would change her mind.

The Respondent's testimony is not persuasive. Although a form signed by a patient indicating the patient's desire to leave a medical facility or a physician's care against medical advice serves as a protection to physicians, it also protects the patient. The use of this form is a clear indication that both the physician and the patient had full knowledge of the severity of the medical condition and the need for continual medical treatment, but the patient refused to follow the physician's advice. The fact that the Respondent did not provide the patient with this form is another indication of the Respondent's casual approach to informing Patient A of the severity of her condition, and his overall lack of professionalism and competence.

Lastly, the Respondent's claim that the patient left against medical advice was not supported by the testimony of Patient A's mother, Ms. Holste. Ms. Holste testified that, although the Respondent told her that he was having a difficult time removing the placenta, he never informed either her or her daughter that they needed to go to a hospital right away to have the placenta removed or that Patient A's medical condition could be potentially life threatening. Ms. Holste's

testimony is consistent with the interview she gave the Board's investigator and it is also consistent with Patient A's interview. Although Ms. Holste testified by telephone, I found her testimony to be detailed and compelling. She provided a detailed account of what transpired from the first day Patient A arrived at the Clinic through the emergency situation she found herself in when she discovered her daughter was excessively bleeding and non-responsive in the gas station bathroom. Her testimony was compelling and convincing when she explained that she would have never have left the Clinic had the Respondent told her that Patient A could not leave the Clinic until the placenta was removed. Further, she would have taken Patient A immediately to a nearby hospital if the Respondent had told her to do so. Ms. Holste's testimony is further supported by the fact that the Respondent did not even provide Patient A with written discharge instructions.

The Respondent argues that Ms. Holste was preoccupied by caring for Patient A's infant son in the waiting room and that she was not present at all times when the Respondent spoke with Patient A about her need to stay at the Clinic or to go to another hospital right away. The Respondent's claims are not persuasive. Ms. Holste was subjected to cross-examination and not once in her testimony did she waiver from her strong assertion that the Respondent did not tell her or her daughter that Patient A had to stay at the Clinic or be transported to a hospital or that Patient A's condition could be life threatening.

For all the reasons stated above, I find that the Respondent was unprofessional in providing medical care to Patient A and that he did violate the standards of quality care in his treatment of Patient A. Md. Code Ann., Health Occ. § 14-404(a)(3)(ii) and (22).

B. The Respondent's failure to keep adequate medical records.

The Respondent did not meet the standard of practice with regards to documenting Patient A's medical records. Dr. Berger, in addition to presenting testimony on the standard of care, also

provided testimony on the standard of practice regarding medical records documentation. Dr. Berger is familiar with the standard of practice regarding medical recordkeeping involving pregnancy terminations as he is Board certified in OB/GYN and he has numerous years of practical experience. Dr. Berger reviewed all of Patient A's medical records and he found numerous deficiencies in the Respondent's recordkeeping practices. He testified extensively and in great detail about the omission of information in Patient A's medical records that should have been documented by the Respondent. His testimony is summarized below.

Patient A was treated at the Clinic for a second trimester termination of pregnancy. The entire procedure could not be done on one day; instead, it took three days. Throughout Patient A's treatment at the Clinic on those three days the Respondent failed to document necessary medical information in the patient's medical record:

1. October 23, 2007

The Respondent did not record the time he placed laminaria in Patient A's vagina to ripen and dilate her cervix. During this procedure Patient A was given IV sedation with controlled dangerous substances; however, the Respondent did not list what those medications were, the dosages or the times administered;

2. October 24, 2007

The Respondent did not record the time he removed the laminaria that he had inserted in Patient A the previous day. He again gave the patient IV sedation, but he did not list what those medications were, the dosages or the times administered. There was no documentation reflecting what the patient's vital signs were on this day. The record for this day reflects that Patient A's membranes ruptured but there was no notation included listing the time the rupture occurred and whether it was done artificially or spontaneously; and

3. October 25, 2007

The Respondent performed the termination procedure on this date but the record does not have listed the start and end time for the procedure. He gave the patient IV sedation and this time he did note the medications and dosages but he did not include the time the sedation was given. He noted on the medical record for this date that the patient did have "lots of blood clots," and that he used adjunctive measures to facilitate the delivery and/or to stop the bleeding, including obstetrical maneuvers, sharp curettage of the endometrium, vacuum, CNS decompressions and uterine massage, but he did not document the estimated blood loss, any vital signs, or the pulse oximetry. He failed to document the fetal weight or the estimated gestational age. Lastly, there were no discharge instructions documented.

Dr. Berger opined that the Respondent's failure to include all of the information listed above was not in accordance with the standard of practice regarding adequate medical record documentation, as the information that was omitted is necessary to determine if the patient was adequately monitored during the procedure and the care and treatment she received was proper.

The Respondent did not provide any evidence to dispute Dr. Berger's testimony regarding the need to adequately document a patient's medical records and the fact that in this case it was not done. For his part, the Respondent only provided explanations for why the records had missing information, including that his staff failed to record the information and also that he had provided information to the patient in the consent forms that she signed regarding the type of IV sedation she was receiving.

The Respondent's explanations are mere excuses and do not provide a sound rationale for finding that his method of recordkeeping is consistent with the standard of practice. The standard of practice requires that adequate medical records must be maintained by a physician because a properly

kept medical record helps a physician avoid errors in treatment and it assists the physician in focusing attention on important symptoms and findings, and allows for more accurate diagnoses. *See* State Ex.

22. As testified to by Dr. Berger, all of the information that was missing from Patient A's medical records is necessary information relied upon by a physician to adequately monitor and diagnose a patient.

Accordingly, I find that the Respondent failed to maintain adequate medical records for the care and treatment he provided to Patient A. His inadequate medical record documentation is a violation of section 14-404(a)(40).

II. The appropriate sanction.

The State recommends that the Respondent's license to practice medicine be revoked because of the Respondent's poor medical judgment and his failure to comprehend the severity of his actions.

In contrast, the Respondent argues that his lack of judgment in this case was allowing the patient to leave the Clinic instead of insisting that she be transported to a hospital. He argues that his forty years as a practicing physician should be considered, especially since this is the first time he has come before the Board regarding a claim that he violated the standard of care in his treatment of a patient.

The Respondent's unprofessional conduct and violation of the standard of care placed Patient A in a life threatening situation. Dr. Berger explained in great detail the consequences that can result when a termination of pregnancy is partially done and a patient leaves a medical facility without having had the placenta removed from her uterus. Ms. Holste's testimony brought to light the horrific ordeal Patient A experienced sometime after they left the Clinic. Her chilling testimony painted a vivid picture of Patient A bleeding excessively and lying slumped over and non-

responsive in the gas station bathroom. The bleeding was so excessive that emergency personnel at first refused to remove Patient A from the bathroom because they believed she had performed an abortion in the bathroom. The full extent of exactly what Patient A suffered as a result of the Respondent's violations was clearly established through the testimony of Dr. Lester-Simmonds, the OB/GYN who treated Patient A once she arrived at Potomac.

Dr. Lester-Simmonds testified that Patient A arrived at Potomac in hemorrhagic shock due to the loss of blood she suffered. Further, her pulse was elevated and her blood pressure was low. Patient A was still bleeding when she arrived at Potomac and her condition was determined to be in a critical state. Blood work done at Potomac revealed that Patient A's hemoglobin and hematocrit levels were below normal and that her levels decreased even further after Dr. Lester-Simmonds suctioned out the placenta and performed a D and C. Consequently, because of the loss of blood, Patient A had to receive a blood transfusion.

Patient A's critical state upon her arrival at Potomac was due to the Respondent's decision to allow her to leave the Clinic when he had only done a partial termination of pregnancy. As a practicing OB/GYN for many years, the Respondent was fully aware that products of conception must be removed when a termination of pregnancy procedure is done, and that excessive bleeding will occur once the placenta comes out. Also, because of his experience in the field of OB/GYN, he has full knowledge of the need for immediate medical intervention if a patient does in fact have placenta accreta. Yet, despite knowing all of this, he allowed Patient A to leave the Clinic when he had only performed a partial procedure and he was uncertain if Patient A had placenta accreta. Regardless of whether he knew the patient had to travel a short or long distance to get home, the Respondent should never have allowed Patient A to leave the Clinic with the placenta still in her uterus.

In addition, it is quite concerning that throughout his testimony, the Respondent failed to

recognize the importance of documenting any monitoring he did of Patient A throughout the three days she underwent treatment at the Clinic. His lack of judgment in that regard leads me to conclude that his lack of documentation was not only due to poor recordkeeping but also because the Respondent failed to adequately monitor the patient throughout the procedure.

The Respondent was sanctioned before by the Board for pleading guilty to Medicaid fraud. For that conduct, which involved a financial crime, his license was revoked and eventually reinstated after the Respondent served a period of probation. In this matter, where the charges concern violations of standards of care that placed a patient in a life-threatening position, a lesser sanction than revocation is not appropriate.

Thus, for all these reasons, I find that the Respondent's poor medical judgment and treatment of Patient A placed Patient A in a life threatening position. Accordingly, his license should be revoked.

CONCLUSIONS OF LAW

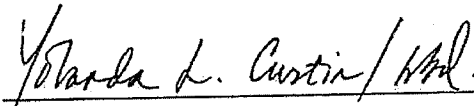
I conclude that the Respondent violated section 14-404(a)(3)(ii), (22) and (40) in his treatment of Patient A. I further conclude that because of these violations the Board may discipline the Respondent. Md. Code Ann., Health Occ. § 14-404(a).

PROPOSED ORDER

I **PROPOSE** that the charges filed by the Board on July 27, 2010, against the Respondent for violations of section 14-404(a)(3)(ii), (22) and (40) be **UPHELD**.

I **PROPOSE** that the Respondent's license to practice medicine be **REVOKED**.

August 16, 2011
Date Decision mailed



Yolanda L. Curtin
Administrative Law Judge

YLC/
#125554

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party may file exceptions, in writing, to this Proposed Decision with the Board of Physicians within fifteen days of issuance of the decision. Md. Code Ann., State Gov't § 10-216 (2009) and COMAR 10.32.02.03F. The Office of Administrative Hearings is not a party to any review process.

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