

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

* * * * *

CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT

The Maryland State Board of Physicians (the "Board") hereby charges MICHAEL A. BASCO, M.D. (the "Respondent") (D.O.B., 10/05/1959), License Number D72935, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2009 Repl. Vol.); and the Code of Maryland Regulations ("COMAR") tit. 10, § 32.12 *et seq.*

The pertinent provisions of the Act provide the following:

H.O. § 14-404

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

(3) Is guilty of: (ii) unprofessional conduct in the practice of medicine; [and/or]

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

The pertinent provisions under COMAR provide the following:

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;
- (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.

ALLEGATIONS OF FACT¹

The Board bases its charges on the following facts that the Board has reason to believe are true:

Licensing information

1. At all times relevant to these charges, 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*).

¹ The allegations set forth in this document are intended to provide the Respondent with notice of the Board's charges. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with these charges.

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

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 submitted on 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 in Pennsylvania 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. 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 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 action taken by the Board.

Board Order for Summary Suspension, dated May 29, 2013

9. The Board initiated an investigation of the Respondent after reviewing the Maryland Office of Health Care Quality's ("OHCQ")² investigation of Associates.

10. 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.*

11. 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 its deficiencies placed patients at risk of serious harm

² 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.

or death. OHCQ ordered that Associates immediately cease providing surgical abortions, determining that the public health, safety or welfare imperatively required emergency action.

12. The Respondent provided abortion services at Associates' offices during the time of OHCQ's survey in February 2013 and was also 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."

13. 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 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.

14. 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 S

15. uspension against him. After hearing arguments from the Respondent and the assigned administrative prosecutor, the Board issued an order continuing the summary suspension.

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 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 2, 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 unattended for a period of time after he administered conscious sedation to her and performed 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 correction plans.

21. OHCQ then received an anonymous complaint, dated May 7, 2013, regarding treatment a patient (the "Patient") received at Associates' Baltimore office on

May 4, 2013, when the Respondent was scheduled to perform surgical abortions at the clinic.

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

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

26. After a period of time, the Respondent contacted the Patient by cell phone and discovered that she was still in the office. He then verbally offered the Patient three options: (a) The Patient could travel in two days to Associates' Frederick office for the

administration of laminaria, a type of seaweed that is used to dilate the cervix, 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 the Patient to a site in New Jersey where a surgical abortion could be performed with the Patient under general anesthesia; or (c) The Respondent could attempt to identify a local hospital that could complete a surgical abortion procedure.

27. The Patient reportedly chose the first option and left the facility. Associates staff provided no written discharge instructions. The Patient's medical record did not accurately describe what occurred and what was discussed with the Patient during the encounter. In addition, the Respondent did not provide adequate written discharge instructions to the Patient. Later that day, the Patient presented to another facility that was not associated with Associates, where the staff completed a surgical abortion procedure with no reported complications.

28. 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.

29. 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 the Patient. These deficiencies constitute 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.

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

31. The Respondent's conduct, as described above, constitutes, in whole or in part, unprofessional conduct in the practice of medicine, in violation of H.O. § 14-404(a)(3)(ii). The Respondent provided abortion services at Associates during which time its offices violated numerous provisions of the State's surgical abortion facility regulations, which could have resulted in serious or life-threatening harm of death to patients. The Respondent continued to provide abortion services at Associates that are not in compliance with the State's surgical abortion facility regulations.

32. The Respondent practiced medicine at Associates with an unauthorized person or persons or aided an unauthorized person or persons in the practice of medicine there, in violation of one or more of the following provisions of the Act: unprofessional conduct in the practice of medicine, in violation of H.O. § 14-404(a)(3)(ii); and/or 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.

NOTICE OF POSSIBLE SANCTIONS

If, after a hearing, the Board finds that there are grounds for action under Md. Health Occ. Code Ann. §§ 14-404(a)(3)(ii) and/or (18), and COMAR 10.32.12.04E and 05B, the Board may impose disciplinary sanctions against the Respondent's license, against the Respondent's license in accordance with the Board's regulations under Code Md. Regs., tit. 10, §32.02.10, including revocation, suspension, or reprimand, and may place the Respondent on probation, and/or may impose a monetary fine.

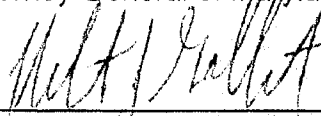
**NOTICE OF DISCIPLINARY COMMITTEE FOR CASE RESOLUTION
CONFERENCE, PREHEARING CONFERENCE AND HEARING**

A conference before the Disciplinary Committee for Case Resolution ("DCCR") in this matter is scheduled for **Wednesday, August 7, 2013, at 10:00 a.m.**, at the Board's office, 4201 Patterson Avenue, Baltimore, Maryland 21215. The Respondent must confirm in writing his intention to attend the DCCR. The Respondent should send his written confirmation of his intention to participate in the DCCR to: Christine Farrelly, Acting Executive Director, Maryland State Board of Physicians, 4201 Patterson Avenue, 4th Floor, Baltimore, Maryland 21215. The nature and purpose of the case resolution conference and prehearing conference is described in the attached letter to the Respondent.

If the case cannot be resolved at the DCCR, a pre-hearing conference and a hearing in this matter will be scheduled at the Office of Administrative Hearings, 11101 Gilroy Road, Hunt Valley, Maryland 21031. The hearing will be conducted in

accordance with § 14-405 of the Act and Md. State Gov't Code Ann. §§ 10-201 et seq.
(2009 Repl. Vol. and 2012 Supp.).

DOUGLAS F. GANSLER
Attorney General of Maryland



Robert J. Gilbert, Deputy Counsel
Health Occupations Prosecution and
Litigation Division
Office of the Attorney General
Suite 201
300 West Preston Street
Baltimore, Maryland 21201

7/17/13
Date