IN THE MATTER OF	*	**BEFORE THE MARYLAND**
Harold O. Alexander, M.D.	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D22219	*	**Case Number:** 7713-0016

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VIOLATION OF PROBATION AND CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT

The Maryland State Board of Physicians (the "Board"), hereby charges Harold O. Alexander, M.D. (the "Respondent"), License Number D22219, pursuant to his probationary terms and conditions and with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") § 14-404(a) (2009 Repl. Vol. & 2013 Supp.).

The pertinent provisions of the Act provide the following:

> (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:
>
> ...
>
> (ii) Unprofessional conduct in the practice of medicine [.]

Md. Regs. Code 10.12.01 provides in pertinent part:

> **.01 Definitions**
>
> ...
>
> B. Terms Defined.
>
> ...

(6) "Surgical abortion facility" means an outpatient facility that provides surgical termination of pregnancy as a regular service...

.02 License Required.

A. A person may not establish or operate a surgical abortion facility without obtaining a license from the Secretary.

...

...

.05 Administration.

...

B. Medical Director.

(1) The surgical abortion facility shall have a medical director who:

(a) Is responsible for the overall medical care that is provided by the facility; and
(b) Advises and consults with the staff of the facility on all medical issues relating to services provided by the facility.

...

.06 Personnel.

A. Qualifications of Physicians and Staff. A facility shall ensure that all physicians and other health professionals who are employees or contractual staff have been appropriately trained and licensed or certified under the Health Occupations Article, Annotated Code of Maryland.

...

.07 Surgical Abortion Services.

A. Surgical abortion procedures shall be performed in a safe manner by a physician credentialed by the facility under Regulation .06 of this chapter.

...

E. If anything other than an unsupplemented local anesthetic is needed to accomplish a surgical procedure, a health practitioner as described in Regulation .08 of this chapter shall conduct a pre- anesthesia evaluation and document the anesthetic risk to the patient.

...

.08 Anesthesia Services.

A. Anesthetics shall be administered by health practitioners who are licensed, certified, or otherwise authorized to do so under the Health Occupations Article, Annotated Code of Maryland.

B. Anesthetics shall be administered only by a:

(1) Qualified anesthesiologist;
(2) A physician qualified to administer anesthesia; or
(3) A certified registered nurse anesthetist in accordance with:

(a) Health Occupations Article, § 8-205, Annotated Code of Maryland; and
(b) COMAR 10.27.06.

.09 Emergency Services.

...

B. The facility shall have:

(1) A registered nurse available on site for emergency treatment whenever there is a post-operative surgical abortion patient in the facility;

...

.11 Pharmaceutical Services.

A. The surgical abortion facility shall:

...

(2) Develop and implement policies and procedures for pharmacy services in accordance with accepted professional practice.

B. Administration of Drugs.

(1) Staff shall prepare and administer drugs according to established policies and acceptable standards of practice.

...

.13 **Medical Records.**

A. The facility shall maintain a complete, comprehensive, and accurate medical record for a patient.

...

The relevant terms of the Board's April 4, 2013 Final Order Terminating Suspension and Imposing Probation provide the following:

> ...**ORDERED** that Dr. Alexander is placed on **PROBATION** for a minimum period of **TWO YEARS**, and Dr. Alexander shall fully and satisfactorily comply with the following terms and conditions of probation:
>
> ...
>
> 6. Dr. Alexander shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101--14-702, and all laws and regulations governing the practice of medicine in Maryland...

ALLEGATIONS OF FACT[1]

I. BACKGROUND

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

[1] The allegations set forth in this document are intended to provide the Respondent with notice of the alleged 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.

1. At all times relevant to these charges, the Respondent was and is a physician licensed to practice medicine in the State of Maryland. The Respondent was initially licensed in Maryland on or about June 21, 1978, and his license is presently active. The Respondent's license expires on September 30, 2014.

2. The Respondent is board-certified in Obstetrics and Gynecology.

3. At all times relevant to these charges, the Respondent practiced medicine at Practice A[2] in Forestville, Maryland, conducting medical and surgical abortions and gynecologic services. The Respondent was the Medical Director and General Manager of Practice A.

4. At all times relevant to these charges, the Respondent did not hold hospital privileges.

5. At all times relevant to these charges, Practice A was not a licensed facility for the performance of surgical abortions as required by Md. Code Regs. 10.12.01.02.

6. At all times relevant to these charges, the Respondent employed two employees at Practice A: Employee A, hired as the "Clinical Administrator" and office manager, and Employee B, hired as a receptionist and medical assistant.

7. On October 25, 2013, the Board ordered the Respondent to cease and desist from performing any surgical abortions and from administering any Controlled Dangerous Substances ("CDS"), including but not limited to sedation. On December 19, 2013, following a post-deprivation hearing, the Board modified the October 25, 2013 Cease and Desist Order to prohibit the Respondent from

[2] In order to maintain confidentiality, facility names will not be used in this document

performing any surgical abortions at an unlicensed surgical abortion facility and ordered that he only perform such procedures at a surgical abortion facility licensed by Md. Code Regs. 10.12.01.02; and to limit the Respondent's prescription/administration of CDS consistent with the Drug Enforcement Administration ("DEA") Memorandum of Agreement dated October 28, 2013.

PRIOR DISCIPLINARY HISTORY

8. On or about May 14, 2012, the Board charged the Respondent with unprofessional conduct in the practice of medicine, failure to meet the standard of quality medical care and inadequate medical recordkeeping. The unprofessional conduct charges were based on allegations of sexual misconduct including inappropriate comments the Respondent made toward patients, complaints the Respondent hugged and kissed patients, and inappropriate prescribing by the Respondent including self-prescribing and prescribing to family members and friends.

9. On or about August 22, 2012, the Respondent entered into a Consent Order with the Board, resolving the charges set forth in ¶ 8. The Consent Order imposed a minimum of a three month suspension of the Respondent's medical license, and a minimum of two years of probation with terms and conditions, conditioned upon an evaluation finding the Respondent safe to practice medicine.

10. On April 4, 2013, the Board issued a Final Order terminating the Respondent's suspension and placing him on a minimum of two years of probation with terms and conditions.

11. At all times relevant to these charges, the Respondent was under the probationary terms and conditions imposed by the Consent Order.

CURRENT COMPLAINT AND OHCQ INSPECTION

12. On or about October 21, 2013, the Office of Health Care Quality ("OHCQ") conducted a licensure inspection of Facility A ("inspection") and based on the results of the inspection as set forth below, OHCQ filed a complaint with the Board.

13. The inspection included an on-site visit by OHCQ surveyors ("surveyors"), an interview of the Respondent and a review of Facility A's policy and procedure manual, personnel files, quality assurance and infection control program and professional credentialing.

14. During the inspection, the surveyors reviewed the medical records of ten of the Respondent's patients (identified as Patients A through J) who had received abortions conducted by the Respondent between June 12, 2013 and October 14, 2013, when Facility A was unlicensed as a surgical abortion facility. The Respondent reported to the surveyors that he performed surgical abortion procedures at Facility A on a routine basis.

15. The inspection revealed and the Respondent acknowledged that during all times relevant there was no registered nurse ("R.N.") on site when the Respondent performed surgical abortion procedures. Md. Code Regs [3]. 10.12.01.09B (1) requires that an R.N. be available on site for emergency

[3] Nine of the patient records reviewed had first trimester pregnancies; one patient (Patient B) underwent a saline with cytotec instillation for a mid-trimester abortion.

treatment whenever there is a post-operative surgical abortion patient in the facility.

16. The inspection revealed that the Respondent's employees at Facility A included only Employee A and Employee B, neither of whom were licensed by the Board or the Maryland Board of Nursing in any capacity.

17. The Respondent documented that he "trained" Employees A and B on or about August 15, 2012 to administer "sedating medications" to patients upon order from the physician.[4, 5]

18. According to the Respondent's handwritten notes, conscious sedation includes CDS such as IV diazepam,[6] IV fentanyl citrate,[7] IV midazolam[8] and IV Demerol.[9]

19. During the inspection, the Respondent stated to the surveyors that he is not the individual who administers the conscious sedation to patients during the procedures. According to the surveyors, the Respondent represented to them during the survey that the Respondent "tells" the medical assistants when to push the medications through the IV ports.[10, 11]

20. The Respondent was unable to provide the surveyors with policies and procedures in accordance with professional practice for pre-drawn medications.

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[4] The Respondent is the only physician performing surgical abortions at Facility A.
[5] The surveyor's notes reflect that Medical Assistant A was not hired until June 2013. Medical Assistant B was hired in February 2012.
[6] Schedule IV benzodiazepine.
[7] Schedule II CDS.
[8] Schedule IV benzodiazepine.
[9] Schedule II CDS.
[10] The Respondent subsequently denied this to be the case in an interview conducted by the Board's staff on October 25, 2013, and in a written submission to the Board.
[11] The Respondent subsequently denied that he had authorized Employees A and B to administer sedating medications to surgical abortion patients.

narcotic medication management, narcotic log documentation and for the administration of IV sedation.

21. On October 21, 2013, the surveyors located four plastic bins in the narcotics cabinet that contained syringes with medications including CDS. The syringes were labeled only with the name of the medication, and failed to include the date the medication had been drawn into the syringe, the concentration of the medication, the expiration date of the medication, or the initials of the person who had drawn up the medication. The Respondent was unable to provide the surveyor with the corresponding medication vials.

22. The Respondent stated that Employee A routinely took the narcotic log book and the patient medical records home each night after office hours. Medical Assistant A routinely typed the contents of the narcotics log at her home each evening to record the CDS that had been administered to patients during surgical abortion procedures.

23. Facility A's narcotic log failed to include signatures by licensed individuals of CDS counts at the beginning and end of each shift.

24. According to the surveyors, the Respondent stated that he provided Employees A and B with keys to the facility's CDS cabinet.

25. According to the surveyors, the Respondent stated that Facility A did not have a policy and procedure for documenting the administration of narcotics, for the counting of narcotics or for the IV administration of pre-drawn CDS.

26. The Respondent's actions as outlined in pertinent part above constitute a violation of Md. Code Regs. 10.12.01.08 which requires that anesthetics be

administered by health practitioners who are licensed, certified, or otherwise authorized to do so under the Health Occupations statute (which include a physician qualified to administer anesthesia or a certified registered nurse anesthetist).

27. The Respondent's actions as outlined in pertinent part above constitute a violation of Md. Code Regs. 10.12.01.11A(2) which requires that the facility develop and implement policies and procedures for pharmacy services in accordance with accepted professional practice.

28. The Respondent's actions as outlined in pertinent part above constitute a violation of Md. Code Regs. 10.12.01.11B(1) which requires that staff prepare and administer drugs according to established policies and acceptable standards of practice.

MEDICAL RECORD-KEEPING

A review of ten patient records (identified as Patients A through J) produced by the Respondent at the request of the surveyors, revealed the following:

29. The Respondent performed surgical abortions on Patients A, D, F, G, H, I and J (between June 10, 2013 and October 14, 2013), all young women with first trimester pregnancies.[12] All seven patients received conscious sedation by IV including different combinations of Nubain,[13] diazepam and/ or Demerol. There was a documented set of preoperative vital signs for each patient, but the

[12] Patient B underwent a curettage following an explosive unattended delivery Patient C's record did not contain documentation of the type of anesthesia received. Patient E received local anesthesia during her procedure.

[13] Non-scheduled opioid analgesic used for pain and anesthesia

Respondent failed to document any postoperative vital signs. Moreover, there was no documentation of the patients' postoperative status, including bleeding.

30. With regard to Patients A, D, F, G, H, I and J, the Respondent failed to document the following criteria as specified in Practice A's Policy and Procedure Manual, before the patients were discharged:

> The patient must be ambulatory with a stable blood pressure and pulse, and bleeding must be controlled.

31. With regard to Patients A, D, F, G, H, I and J, the Respondent failed to ensure that vital signs were documented every 15 minutes or at discharge as specified by Facility A's Policy and Procedure Manual, which provided:

> Vital signs every 15 minutes.

32. The surveyor requested to review the medical records of two additional patients who had undergone surgical abortions at Practice A on October 16, 2013.[14] The Respondent was unable to recall the names of the two patients or produce the requested medical records.

33. As outlined in pertinent part above, the Respondent violated Md. Code Regs. 10.12.01.13 which requires that the facility shall maintain a complete, comprehensive, and accurate medical record for a patient.

BOARD'S INTERVIEW OF THE RESPONDENT

34. On or about October 25, 2013, the Board's staff interviewed the Respondent under oath with regard to the allegations.

35. The Respondent stated that he had performed approximately 150 abortions at Practice A since June 2013.

[14] The Respondent had represented to the surveyor that he had conducted two surgical abortions on October 16, 2013.

36. The Respondent stated that both Employees A and B assisted him with patient care throughout the abortion procedures.

37. According to the Respondent, in November 2012, he applied to OHCQ for a surgical abortion facility license. At the time, his medical license had been suspended.

38. The Respondent acknowledged that in March 2013, he spoke with the Director of OHCQ (Dr. N) and she informed him that in order for him to be granted a surgical abortion facility license, he had to hold a medical license.

39. The Respondent stated that on or about April 19, 2013, OHCQ notified him that his surgical abortion facility license had become inactive.

40. The Respondent stated that on April 22, 2013, he applied to OHCQ for reinstatement of his surgical abortion facility license.

41. The Respondent acknowledged that he did not employ a registered nurse at Practice A.

42. The Respondent stated that Employee A was responsible for documenting the narcotics log and often she completed the documentation at home after office hours. The Respondent was aware Employee A brought patient records to her personal home for reference in completing the narcotic log documentation.

43. The Respondent stated that he monitors the pulse-oximetry of the conscious sedation patients for the first 15 minutes they are in the recovery room.

44. The Respondent acknowledged that he does not have someone continuously monitoring the postoperative patients in the recovery room once "we deem them to be stable."

BOARD'S INTERVIEW OF EMPLOYEE A

45. On November 14, 2013, the Board's staff interviewed Employee A by telephone under oath.

46. Employee A stated that she was hired by the Respondent effective June 1, 2013 as a part time "assistant office manager and medical assistant." She had worked for the Respondent approximately three years prior to this date. Employee A was not a licensed health care worker and stated she had "no medical background."

47. Employee A denied any knowledge of an August 15, 2012 Orientation Checklist addressing moderate sedation that had been completed by the Respondent and was present in her personnel file.

48. Employee A assisted the Respondent with surgical abortions.

49. Employee A stated that routinely patients' vital signs were not monitored in the recovery room following the surgical abortion procedures.

BOARD'S INTERVIEW OF EMPLOYEE B

50. On November 12, 2013, the Board's staff interviewed Employee B by telephone under oath.

51. Employee B stated that she was hired by the Respondent as a part-time receptionist[15] in February 2011.

[15] Employee B also works as a receptionist for a physician who shares office space with the Respondent (Dr. M). Dr. M's practice is not affiliated with the Respondent's practice

52. Employee B described her education as "high school." She is not licensed in Maryland in any health care occupation.

53. Employee B described her job responsibilities as answering the telephone, assisting the Respondent with "paperwork" and that she reviews "patient instructions" with the Respondent's patients.

54. Employee B stated that she "check[s] on ...patients" if the Respondent has to leave the room. She stated that in the Recovery Room if pulse-oximetry on a patient goes off, she will notify the Respondent.

55. Employee B denied taking vital signs while the patients were in the recovery room.

56. Employee B denied any knowledge of an August 15, 2012 Orientation Checklist addressing moderate sedation that had been completed by the Respondent and was present in her personnel file.

57. Employee B stated that Employee A, the only other employee at the Respondent's practice, assisted the Respondent with patient care. She confirmed that the Respondent did not employ a registered nurse in his practice.

Charges

58. The Respondent's actions as outlined in pertinent part above constitute unprofessional conduct in the practice of medicine in violation of Health Occ. § 14-404(a)(3)(ii), and are a violation of the terms of his probation pursuant to the Board's April 4, 2013 Consent Order.

NOTICE OF POSSIBLE SANCTIONS

If, after a hearing, the Board finds that there are grounds for action under Md. Health Occ. § 14-404 (a) (3) (ii) and/or whether or not the Respondent's actions constitute a violation of the terms of probation pursuant to the April 4, 2013 Consent Order, the Board may impose disciplinary sanctions against Respondent's license, including revocation, suspension, reprimand and/or probation and/or may impose a fine.

NOTICE OF DISCIPLINARY COMMITTEE FOR CASE RESOLUTION[16]

A Disciplinary Committee for Case Resolution ("DCCR") in this matter is scheduled for **March 12, 2014, at 9:00 a.m.** at the Board's office, 4201 Patterson Avenue, Baltimore, Maryland 21215. The nature and purpose of the DCCR is described in the attached letter to the Respondent. If this matter is not resolved on terms accepted by the Board, an evidentiary hearing will be scheduled.

DOUGLAS F. GANSLER
ATTORNEY GENERAL OF MARYLAND

1/13/14
Date

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[16] Md. Code Regs. 10.32.02.03E(9) (2013), effective January 21, 2013, renamed the Case Resolution Conference ("CRC") to the Disciplinary Committee for Case Resolution ("DCCR") without any changes as to its functions.