IN THE MATTER OF	*	**BEFORE THE MARYLAND**
Harold O. Alexander, M.D.	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D22219	*	**Case Number: 2015-0019A**

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CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT

Disciplinary Panel A of the Maryland State Board of Physicians (the "Board"), hereby charges Harold O. Alexander, M.D. (the "Respondent"), License Number D22219, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") § 14-404(a) (2014 Repl. Vol.).

The pertinent provisions of the Act provide the following:

> (a) *In general.* -- Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
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> ...
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> (3) Is guilty of:
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> ...
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> (ii) Unprofessional conduct in the practice of medicine;
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> ...
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> (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[.]

ALLEGATIONS OF FACT[1]

I. BACKGROUND

Disciplinary Panel A bases its charges on the following facts that it has cause to believe are true:

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, but he is under an Order of probation as set forth below in ¶¶ 9 and 10. The Respondent's license is scheduled to expire on September 30, 2016.

2. At all times relevant to these charges, the Respondent practiced medicine at Practice A[2] in Forestville, Maryland, conducting medical abortions and gynecologic services. Practice A is located in an office owned by Dr. M, an obstetrician-gynecologist. Dr. M maintains a separate clinical practice from the Respondent.

3. At all times relevant to these charges, the Respondent's hours at Practice A were part-time, during the evenings and on Saturdays.

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

II. PRIOR DISCIPLINARY HISTORY

5. On August 22, 2012, the Respondent entered into a Consent Order with the Board in order to resolve May 14, 2012 charges under Health Occ. § 14-404(a)(3)(ii), (22) and (40) alleging that he failed to meet the standard of quality care in his care of

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[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.

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

obstetric and gynecology patients, that his documentation was inadequate and that he had engaged in unprofessional conduct with patients based on kissing, hugging and inappropriate comments of a sexual nature, and by inappropriately shredding medical records. The August 22, 2012 Consent Order imposed a minimum period of three months of suspension, and two years of probation with conditions.

6. On April 4, 2013, the Board issued an Order terminating the suspension of the Respondent's medical license and imposing a minimum of two years of probation with terms and conditions.

7. On December 19, 2013, based on investigative findings that the Respondent was performing surgical abortions in an unlicensed facility, the Board issued a Cease and Desist Order that required the Respondent to immediately cease and desist from performing any surgical abortions in an unlicensed facility, and ordered that he must adhere to a Drug Enforcement Administration ("DEA") agreement regarding administering and prescribing any controlled dangerous substances ("CDS").[3]

8. On April 16, 2014, the Respondent entered into a Consent Order in order to resolve subsequent charges filed January 13, 2014 that he violated probationary terms and conditions of the April 4, 2013 probationary order, and under Health Occ. § 14-404(a)(3)(ii) that he was performing surgical abortions in violation of Md. Code Regs. 10.12.01 *et seq*. The April 16, 2014 Consent Order imposed a three month suspension of the Respondent's license and ordered that he be placed on a minimum of three years of probation with conditions.

[3] This reflects amended language of the initial Cease and Desist Order issued October 25, 2013, following a hearing on the Cease and Desist Order.

9. On July 21, 2014, Disciplinary Panel A issued an Order staying the suspension of the Respondent's medical license and placing him on three years of probation with terms and conditions.

10. The Respondent is presently under the terms and conditions of Disciplinary Panel A's July 21, 2014 probationary Order.

III. CURRENT COMPLAINT

11. On or about June 18, 2014, the Board received a complaint from Insurance Company A's Special Investigation Unit alleging that the Respondent had performed a late-term abortion on a patient identified as Patient A, and the procedure had been inappropriately billed as a "miscarriage."[4]

12. After receiving the complaint, the Board initiated an investigation.

13. By letter dated October 7, 2014, the Board's staff notified the Respondent of its investigation during an on-site visit, and requested a written response.

14. On or about October 14, 2014, the Respondent submitted a written response to the Board stating that he had seen Patient A in consultation following a referral for "second trimester pregnancy, multiple congenital anomalies, fetal death *in utero*."

15. In furtherance of its investigation, the Board transmitted patient records and other relevant documents relating to Patient A to two physicians board-certified in obstetrics and gynecology for a peer review.

16. On or about February 11, 2015, the Board received copies of the peer reviewers' completed reports. Both peer reviewers concurred that the Respondent's care of Patient A failed to meet the standard of quality care, and that his actions

[4] The Respondent does not accept third party payments. He requires cash payment for medical care rendered. Patient A submitted the claim to Insurance Company A.

constituted unprofessional conduct in the practice of medicine. The results of the peer review are set forth below.

17. On or about February 13, 2015, the Board's staff sent the Respondent copies of the redacted peer review reports, and provided him an opportunity to file a supplemental response.

18. On or about March 13, 2015, the Respondent filed a supplemental response with the Board.

IV. ON-SITE VISITS AND INTERVIEWS OF RESPONDENT

19. On October 7, 2014, the Board's staff conducted an unannounced site visit of Practice A. During the visit, in response to a Board subpoena for records, the Respondent was unable to provide the Board staff with Patient A's medical record. The Respondent stated that Patient A's medical record was present in a locked cabinet, and he did not have the key. Additionally, he was unable to comply with the Board's subpoena requesting appointment logs.

20. On October 16, 2014 and November 24, 2014, the Board's staff conducted interviews under oath of the Respondent.

October 16, 2014 interview

21. On October 16, 2014, during the Respondent's appearance at the Board's offices, he provided the Board's staff with Patient A's medical record.

22. During the Respondent's interview under oath, when asked again by the Board's staff why he had been unable to provide Patient A's medical record in response to the subpoena issued on October 7, he stated that the record had been off-site under

lock and key for storage. The Respondent was unable to directly respond to questions about how he routinely keeps and maintains patient records.

23. The Respondent stated that he was unable to comply with the October 7 subpoena for appointment logs because he does not keep appointment logs.

24. The Respondent stated that Patient A had contacted his office for a February 28, 2014 appointment.

25. On February 28, 2014, when Patient A presented for care, the Respondent conducted an ultrasound, did not hear a fetal heart rate, and confirmed a fetal death *in utero*. The Respondent stated that on February 28, 2014, Patient A's gestational age was approximately 28 weeks. He stated that the third trimester of pregnancy commences after 28 weeks.[5]

26. The Respondent stated that after performing the ultrasound on Patient A, he then proceeded with a "second trimester induction of labor" using Mifeprex,[6] and laminaria.[7] Additionally, the Respondent stated that he performed intra-amniotic injections of Digoxin[8] and lidocaine.[9]

27. The Respondent stated that he discharged Patient A to a hotel with instructions related to medication and to return to his office for evaluation when she had an onset of pain. Patient A returned to the Respondent's office on March 1, 2014, at 5:00 a.m. and delivered the fetus at 9:00 a.m. The Respondent discharged her from

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[5] The peer reviewers opined that the third trimester of pregnancy begins at week 28.
[6] Mifeprex is the only Food and Drug Administration (FDA)-approved early option for non-surgical abortion in the first 49 days of pregnancy.
[7] Kelp, which is used to dilate the cervix and induce labor and delivery.
[8] Digoxin is used to induce fetal demise and would generally be used before a dilation and evacuation (D&E) abortion or a second trimester medical abortion.
[9] Lidocaine is a local anesthetic.

care approximately one hour later, at 10:00 a.m., without documented follow-up instructions, aware that she was planning to return to Europe.

November 24, 2014 interview

28. The Respondent stated that he had not performed any third trimester abortions.[10]

29. The Respondent stated that he sees five to ten patients weekly, primarily for medical abortions.

30. The Respondent stated that he transfers all of his patient records to an off-site foundation.

31. The Respondent stated that the procedure he performed on Patient A was termed a "medical induction of a second trimester fetal death *in utero*, with multiple congenital anomalies."

V. PATIENT-RELATED ALLEGATIONS

DOCUMENTATION FROM INSURANCE COMPANY A

32. According to Insurance Company A, at all times relevant, Patient A's health plan only covered "emergent" issues; she was not covered for medical procedures that were planned or scheduled.

33. Patient A represented to Insurance Company A that she was approximately 29 weeks pregnant on or about March 1, 2014, and she was travelling from her home in Europe to the United States for business purposes.

34. Patient A submitted a claim to Insurance Company A for a "miscarriage" she stated that she had suffered at 29 weeks. She represented to the insurance company

[10] The peer reviewers dispute the Respondent's interpretation of when the third trimester of pregnancy begins.

that she had seen the Respondent for medical care and had spent "a couple of days in a hospital and a hotel room." The Respondent had billed her $9,500 for the following:

> Patient [A] had a spontaneous loss of pregnancy and was delivered of a non-viable pregnancy 3/1/14 (Dead Fetus *in utero*).

DOCUMENTATION FROM PATIENT A'S MEDICAL RECORDS

35. Patient A, a female in her 20s residing in Europe, initially presented to the Respondent on or about February 28, 2014. The Respondent documented that Patient A reported to the Respondent she wanted an abortion conducted because of a "defect." This was Patient A's first pregnancy.

36. The Respondent documented Patient A's last menstrual period ("LMP") had been reported as August 14, 2013.[11] According to Patient A's LMP reported as August 14, the fetal gestational age on February 28 was between 28 and 29 weeks.

37. Patient A provided the Respondent with copies of four ultrasound reports that had been conducted by other practitioners overseas:

a. October 21, 2013 ultrasound conducted at Facility A in Ireland showed a fetal gestational age of 10 weeks, with the estimated due date as May 17, 2014.

b. January 6, 2014 ultrasound conducted in Fiji showed a fetal gestational age of 21 weeks and 1 day, with the Estimated Due Date as May 18, 2014. There was no definite fetal abnormality seen.

c. February 22, 2014 ultrasound conducted in Facility B showed fetal defects indicative of spina bifida. The Estimated Due date was May 16, 2014. The gestational age was estimated to be between 27 weeks and 28 weeks and 1 day.

d. An undated ultrasound at "28 weeks gestation" conducted at Facility A in Ireland showed spina bifida, meningomyelocele and a right club foot.

[11] Patient A's LMP was listed as August 9, 2013 during her ultrasound that was conducted on February 22, 2014, and August 10, 2013, at two prior ultrasounds conducted in Ireland at Facility A. The Respondent had received copies of all of these ultrasound reports and signed that he had reviewed them.

38. Patient A signed a consent form for the Respondent to perform a mifeprex/misoprostol[12] abortion procedure.

39. On February 28, 2014, the Respondent conducted an ultrasound and documented the fetal age based on the biparietal diameter to be 28 weeks and that he was unable to locate a fetal heart rate. He noted a history of multiple anomalies.

40. The Respondent documented that he would administer Digoxin and lidocaine despite the absence of a fetal heart rate.

41. On February 28, 2014, the Respondent inserted laminaria, prescribed mifeprex, and injected Digoxin and lidocaine, but failed to document the time any of these medications were administered.

42. The Respondent documented that misoprostol was administered at 5:00 a.m. on March 1, 2014.

43. The Respondent documented that the following medications were administered to Patient A: Nubain[13] at 9:00 a.m., and midazolam[14] at 5:00 a.m., 7:00 a.m., 9:00 a.m. and what appears to be 12:00 p.m. for pain.[15]

44. The Respondent documented the following postpartum care for Patient A: three sets of vital signs and her bleeding/cramping status at 9:15, 9:30 and 9:45 a.m., respectively.

45. The Respondent documented that Patient A received 2cc of intramuscular Pitocin[16] (no time was documented), and issued her a prescription for 15 tablets of

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[12] Misoprostol is a synthetic prostaglandin used in the termination of early pregnancies.
[13] Nonscheduled semi-synthetic opioid used as an analgesic.
[14] A Schedule IV benzodiazepine.
[15] The Respondent documented that Patient A was discharged from his office at 10:00 a.m.
[16] Used to control bleeding after delivery.

Percocet. The Respondent checked off a box on a form that Patient A was stable at discharge.

46. The Respondent did not document his recommendations for follow-up care other than checking off a box on a form stating, "private MD." The Respondent documented Patient A's discharge time as 10:00 a.m.

PEER REVIEW

The peer reviewers concur to the following:

47. The third trimester of an intrauterine ("IUP") pregnancy begins at 28 weeks. The Respondent's ultrasound confirmed that Patient A had at least a 28-week IUP.

48. The standard of quality care for induction of labor on or after 28 weeks gestation required that the Respondent manage the delivery according to the usual obstetric protocols, including referral to a higher level of care facility in which deliveries are conducted due to potential risks that could occur during labor and delivery.[17]

49. The Respondent performed the medical induction of an intrauterine fetal death of a 28-week pregnant patient in an office setting and had no hospital privileges.

50. Digoxin is used to induce fetal death before delivery in termination of pregnancy procedures. Digoxin does not, according to the literature, decrease procedure time, difficulty of the labor/delivery process or alleviate pain.

51. The Respondent performed an intrauterine injection of Digoxin, despite documenting that Patient A had experienced a fetal demise *in utero*.

52. Patient A received moderate intravenous sedation to include Nubain and midazolam. The Respondent failed to clearly document whether it was he who administered the medications.

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[17] See ACOG Practice Bulletin No. 102, March 2009, reaffirmed 2014, pg. 7.

53. The Respondent failed to document the estimated blood loss after delivery of the fetus and a description of the fetus.

54. The Respondent was "unsure" about how he maintained medical records in his practice.

Charges

55. 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 a failure to meet the appropriate standards for the delivery of quality medical and surgical care in violation of Health Occ. § 14-404(a)(22).

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 (22), 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

A Disciplinary Committee for Case Resolution ("DCCR") in this matter is scheduled for **October 14, 2015, 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.

BRIAN E. FROSH
ATTORNEY GENERAL OF MARYLAND

7/8/2015
Date

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