IN THE MATTER OF	*	**BEFORE THE MARYLAND**
Harold O. Alexander, M.D.	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D22219	*	**Case Numbers: 2006-0672, 2009-0925, 2010-0397 & 2011-0357**

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CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT

The Maryland State Board of Physicians (the "Board"), hereby charges Harold O. Alexander, M.D. (the "Respondent") (D.O.B. [redacted]), License Number D22219, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("Health Occ.") § 14-404(a) (2009 Repl. Vol.).

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;

(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.

THE AMA CODE OF MEDICAL ETHICS

The American Medical Association ("AMA") Code of Medical Ethics provides in pertinent part:

Opinion 8.19 – Self-treatment or Treatment of Immediate Family Members

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment...

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. 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, 2012.

2. At the time of the acts described herein, the Respondent was a physician engaged in the private practice of Obstetrics and Gynecology in Capital Heights Maryland, and around December 2007, he relocated to Forestville, Maryland. The Respondent holds hospital privileges at Hospital A.[2] As of May

[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, patient and facility names will not be used in this document, but will be provided to the Respondent on request.

19, 2008, Hospital A "deleted" the Respondent's obstetrical privileges; he maintained privileges only in gynecology.

A. INVESTIGATION RELATING TO STANDARD OF QUALITY CARE & DOCUMENTATION

3. On or about April 5, 2006, the Board received a complaint from a physician at Hospital B, alleging the Respondent had initiated a second trimester abortion on a patient (identified as Patient A for purposes of this document) by saline injection and had subsequently informed the patient to go to the nearest hospital when she began contracting.[3] (Case # 2006-0672)

4. On or about October 26, 2009, for the purpose of conducting a peer review, the Board issued a Subpoena *duces tecum* ("Subpoena") to the Respondent for six medical records: Patients J, K, L, M, N and O. (Case #2009-0925)

5. In response to the Board's October 26, 2009 Subpoena, the Respondent submitted 5 patient records to the Board (J through N). He was unable to locate a patient record for Patient O.

6. On or about February 16, 2010, the Board issued a Subpoena to the Respondent for 9 additional medical records: Patients D, E, F, G, H, I, P, Q and R.

7. On or about March 9, 2010, the Respondent provided the Board with 3 medical records in response to the Board's February 16, 2010 Subpoena: D, E and F. He was unable to locate the following 6 patient records: G, H, I, P and Q.

[3] The Respondent was not able to locate patient records for Patient A, and initially did not recall that she had been a patient that he had treated. Several years later in March 2010, the Respondent submitted a letter to the Board acknowledging that he had performed a mid-trimester abortion on Patient A.

8. During a June 1, 2010 interview conducted by the Board's staff, when the Respondent was asked why he could not locate the patient records identified in ¶¶ 5 and 7, he responded that he had "several reasons" for his failure to produce the records. The Respondent testified that in the process of relocating offices he had been "notoriously lacking" in keeping the records in a particular area; he did not know if they were destroyed or where the records "went." Some of the records had been inadvertently shredded.

9. Also during the June 1, 2010 interview the Respondent testified that with regard to second trimester abortions he had not been aware he was required to keep those records for 7 years. The Respondent shredded those records as he had a concern for the "privacy" of those patients.

10. During the investigation of Case #s 2006-0672 and 2009-0925, the Board transmitted 12 patient records[4] to Permedion, a peer review organization, and requested that a formal peer review of the Respondent's practice be conducted. Permedion assigned the peer review to two physicians board-certified in Obstetrics and Gynecology (hereinafter, the "reviewers").

11. The reviewers concurred that with regard to 2 of the 12 patient records[5] reviewed the Respondent had failed to meet the appropriate standards for the delivery of quality medical and surgical care; and that he failed to keep adequate medical records in 7 of the 12 patient records reviewed.

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[4] Four of the records sent for review did not include an office record from the Respondent (Patients A, G, H and I), as he was not able to locate the patient records.

[5] With regard to an additional three patients reviewed, one of the reviewers opined that the standard of quality care had not been met, however, the other reviewer stated he was unable to reach an opinion with regard to the standard of quality care as to these three patients because the Respondent had failed to submit any medical records in response to the Board's Subpoena.

12. On or about November 8, 2010, the Board sent the Respondent copies of the peer review reports and provided him with an opportunity to provide a written response to the reviewers' opinions cited in the reports.

13. On November 10, 2010, the Respondent submitted to the Board a supplementary written response to the peer review reports.

14. The specific allegations are set forth below.

B. INVESTIGATION RELATING TO INAPPROPRIATE SEXUAL COMMENTS

15. On June 24, 2009, the Board issued an Advisory Letter to the Respondent closing a complaint that had been filed by a female patient alleging he had made unprofessional comments to her of a sexual nature. The Board advised the Respondent in part:

> ...the Board would strongly advise that you refrain from making comments that could be misinterpreted by a patient as being inappropriate or sexually provocative. In the future, the Board may construe these types of comments as unprofessional conduct in the practice of medicine...

16. On or about November 12, 2009, Patient B filed a written complaint with the Board alleging that the Respondent had made inappropriate comments regarding her breasts to her during a procedure he was conducting. (Case # 2010-0397)

17. On or about November 15, 2010, Patient C filed a written complaint with the Board alleging that the Respondent had made sexually inappropriate comments during a procedure to her. (Case #2011-0357)

18. The specific allegations are set forth below.

C. INVESTIGATION RELATING TO INAPPROPRIATE PRESCRIBING

19. During the course of the Board's investigation of the above-referenced complaints, the Board's staff reviewed pharmacy surveys that identified the Respondent had been prescribing Viagra to male friends and had prescribed to family members without maintaining a medical record. Additionally, the pharmacy surveys reflected that the Respondent had self-prescribed medications.

20. The specific allegations are set forth below.

II. PATIENT-RELATED ALLEGATIONS

A. CASE #s 2006-0672 & 2009-0925 PEER REVIEW

PATIENT A

21. Patient A, a 25 year-old female, had a 20+ week intrauterine pregnancy when she presented to Hospital B on March 31, 2006 with cramping, vaginal bleeding and nausea. Patient A's membranes had been ruptured, she had no amniotic fluid and there was a single puncture site on the right lower quadrant of her abdomen; an ultrasound revealed no fetal heartbeat was present. The obstetricians at Hospital B induced labor to complete the termination of pregnancy.

22. On her admission to Hospital B, Patient A presented the complainant attending physician with a receipt she had received from Facility A for $2,000 cash dated March 30, 2006. According to Patient A, she had presented to the

Respondent for an elective abortion, he had injected her intra-abdominally with saline[6] and artificially ruptured her membranes.

23. Patient A provided the complainant with copies of prescriptions issued by the Respondent on March 30, 2006, for Methergine, Doxycycline and Estrostep.[7]

24. The complainant telephoned the Respondent's cell phone number that had been provided by Patient A, and spoke with the Respondent's nursing assistant, GG. GG told the complainant that the Respondent had no medical records on Patient A as she had been seen as a "consult" and that the Respondent was unavailable as he had undergone a surgical procedure.[8]

25. On or about May 11, 2007, the Respondent filed a written response to the Board stating that he had been unable to locate medical records for Patient A and that he "[did] not believe that this is a patient that I have treated."

26. By letter to the Respondent dated February 1, 2010, the Board's staff provided the Respondent with documentation supporting that he had provided medical care to Patient A.

27. By letter dated March 8, 2010, the Respondent submitted a second written response to the Board's staff stating:

> I advised you previously that I have no medical record of treating [Patient A] on March 30, 2006 and no recollection of the patient.

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[6] This was confirmed by the Respondent during an interview with the Board's staff.

[7] Methergine increases the rate and strength of uterine contractions, Doxycycline is an antibiotic and Estrostep is an oral contraceptive.

[8] This information was inconsistent with the Respondent's initiation of Patient A's termination procedure on March 30, 2006, that had been substantiated by a receipt and prescriptions issued by the Respondent. The Respondent stated in a written response to the Board dated November 10, 2010, that he had undergone a medical procedure on March 30, 2006, and denied that the procedure would have prevented him from responding to Patient A had she required care. He did not however, return the complainant's telephone call regarding Patient A.

> Having seen the complaint which is the basis of this case, it is apparent that I did perform a second trimester abortion from [Patient A] on March 30, 2006. According to the complaint, [Patient A] presented to the anonymous author a receipt from [Facility A] and that is my office. Further for patients who are more than twenty weeks pregnant, my practice is to terminate pregnancies with saline intra-amniotic injections as is described in the complaint...
>
> ...

The Respondent however, was not able to produce a medical record for Patient A.

28. The Board's staff conducted an interview of the Respondent on June 1, 2010, and in response to questions regarding Patient A, he stated that after he had injected her with intra-amniotic saline, that since there was no fetal heart rate, he had performed an amniotomy[9] the same day and had instructed her to return to the office the following morning or telephone if she experienced certain symptoms.

29. The standard of quality care required that following Patient A's amniotomy he maintain close contact with Patient A or pre-arrange a follow-up visit with her within 24 hours.

30. The standard of quality care required that an obstetrician make themselves or on-call coverage available for emergency care.

31. The reviewers concurred that with regard to Patient A, the Respondent failed to meet the appropriate standards for the delivery of quality medical and surgical care in violation of Health Occ. § 14-404(a)(22) and that his failure to maintain a medical record for Patient A constituted a violation of Health Occ. § 14-404(a)(40).

[9] Artificial rupture of membranes.

PATIENT D

32. Patient D, a 28 year-old female, underwent a second-trimester abortion (at 19 5/7 weeks) by the Respondent on January 10, 2010. He performed a dilation and evacuation (D&E).

33. The Respondent failed to document a physical examination of Patient D.

34. Patient D was given intravenous sedation, and the Respondent failed to document vital signs other than "VS stable."

35. The Respondent failed to document an adequate operative note, a recovery record or any discharge instructions.

36. The reviewers concurred that with regard to Patient D, the Respondent's failure to maintain an adequate medical record for Patient D constituted a violation of Health Occ. § 14-404(a)(40).

PATIENT F

37. Patient F, a 21 year-old female, presented to the Respondent on October 6, 2009 for a D&E to terminate an intrauterine pregnancy at 18+ weeks.

38. The Respondent conducted the D&E under sedation and a paracervical block.

39. The Respondent failed to document an adequate history, physical examination, record any vital signs or discharge instructions.

40. The Respondent failed to document an adequate operative note.

41. The reviewers concurred that with regard to Patient F, the Respondent's failure to maintain an adequate medical record for Patient F constituted a violation of Health Occ. § 14-404(a)(40).

PATIENT G

42. On or about February 16, 2010, the Board issued a Subpoena to the Respondent for Patient G's medical records. On or about August 24, 2009, the Respondent had prescribed doxycycline 100mg (10 tablets) and methergine 0.2 mg (9 tablets) to Patient G, which she had filled at Pharmacy A on the same date.

43. The Respondent failed to provide the Board with any medical records for Patient G in response to its Subpoena.

44. On or about June 1, 2010, during an interview under oath with the Board's staff, the Respondent testified that he was unable to locate a medical record for Patient G.

45. The reviewers concurred that the Respondent's failure to maintain a medical record for Patient G who had received care from the Respondent, constituted a violation of Health Occ. § 14-404(a)(40).

PATIENT H

46. On or about February 16, 2010, the Board issued a Subpoena to the Respondent for Patient H's medical records. On or about April 23, 2009, the Respondent had prescribed doxycycline 100mg (10 tablets) and methergine 0.2 mg (9 tablets) to Patient H, which she had filled at Pharmacy A on the same date.

47. The Respondent failed to provide the Board with any medical records for Patient H in response to its Subpoena.

48. On or about June 1, 2010, during an interview under oath with the Board's staff, the Respondent testified that he was unable to locate a medical record for Patient H.

49. The reviewers concurred that the Respondent's failure to maintain a medical record for Patient H who had received care from the Respondent, constituted a violation of Health Occ. § 14-404(a)(40).

PATIENT I

50. On or about February 16, 2010, the Board issued a Subpoena to the Respondent for Patient I's medical records. On or about August 17, 2009, the Respondent had prescribed doxycycline 100mg (10 tablets), methergine 0.2 mg (9 tablets), ibuprofen 600 mg (28 tablets), and an ortho evra patch (a birth control patch) with 3 refills to Patient I, which she had filled at Pharmacy A.

51. The Respondent failed to provide the Board with any medical records for Patient I in response to its Subpoena.

52. On or about June 1, 2010, during an interview under oath with the Board's staff, the Respondent testified that he was unable to locate a medical record for Patient I.

53. The reviewers concurred that the Respondent's failure to maintain a medical record for Patient I who had received care from the Respondent, constituted a violation of Health Occ. § 14-404(a)(40).

PATIENT J

54. Patient J was a 28 year-old female obstetrical patient of the Respondent who presented on September 1, 2005, for a routine prenatal office visit. She

had a 36-week intrauterine pregnancy. Patient J had seen the Respondent prenatally for several visits, initially at 16 weeks gestation.

55. On or about September 1, 2005, the Respondent performed a digital pelvic examination and according to the Respondent's progress note, she bled heavily after the examination. The Respondent performed a STAT classical cesarean section in his office and called an ambulance to transport Patient J to Hospital C.

56. When the ambulance arrived, the Respondent accompanied Patient J to the hospital and after arrival at the hospital, closed Patient I's wound and removed part of her left fallopian tube and ovary for "persistent oozing." She received two units of packed red blood cells for an estimated blood loss of 1000 cc.

57. The Respondent's documentation with regard to Patient J's emergency cesarean section including his operative report was inadequate.

58. The reviewers concurred that with regard to Patient J, the Respondent's failure to adequately maintain a medical record for Patient J constituted a violation of Health Occ. § 14-404(a)(40).

PATIENT N

59. Patient N, a 43 year-old female with a history of dysfunctional uterine bleeding, underwent a total abdominal hysterectomy with a bilateral salpingo-oophorectomy by the Respondent on March 5, 2007. Patient N had nausea and vomiting post-operatively, and she was prescribed Phenergan.

60. The Respondent discharged her from the hospital on post-operative day #3 with persistent complaints of nausea and vomiting. The Respondent failed to adequately evaluate whether Patient N's nausea and vomiting had resolved and whether she was tolerating oral intake.

61. On March 12, 2007, Patient N was diagnosed by a physician other than the Respondent with a wound seroma with both staph and strep, and with persistent nausea and vomiting and was readmitted to the hospital for antibiotic therapy.

62. On admission, Patient N's white blood count was elevated at 29,500, her potassium was low at 2.7 and her sonogram showed a pelvic abscess. Additionally, she had an incisional abscess that was drained.

63. The Respondent discharged Patient N to home by telephone order on March 16, 2007.

64. The reviewers concurred that with regard to Patient N, the Respondent failed to meet the appropriate standard for the delivery of quality medical and surgical care in violation of Health Occ. § 14-404(a)(22) by discharging her without adequately evaluating whether her nausea and vomiting had resolved and whether she was tolerating oral intake.

B. CASE #s 2010-0397 & 2011-0357
SEXUAL BOUNDARY VIOLATIONS

66. During the Respondent's June 1, 2010 interview with the Board's staff under oath, he testified that he that he liked to hug people and that he kissed staff members on the forehead. He stated that his actions were a "habit" and were not intended to be sexual.

67. The Respondent also testified that patients had told him in the past that they did not want to be hugged.

PATIENT B (Case # 2010-0397)

68. Patient B, a 57 year-old female, saw the Respondent on October 30, 2009 for a routine initial gynecologic visit.

69. During the visit, Patient B stated in a written complaint to the Board (and under oath on April 15, 2010) that the Respondent made inappropriate sexual comments to her including but not limited to the use of the word, "knocking it" when referring to sexual intercourse. Additionally, according to Patient B, when the Respondent examined her breasts he stated, "...these are not the breasts of a 57 year old woman."

70. After the examination had been concluded, according to Patient B, the Respondent attempted to hug her.

71. The Respondent in a written statement to the Board dated May 26, 2010, admitted that he had "on occasion" used the term "knock it" when "discussing the damage that can occur to the anatomy during intercourse." Additionally, during a June 1, 2010 interview with the Board's staff, he testified that he had used the term.

72. During the Respondent's June 1, 2010 interview with the Board's staff, the Respondent testified that he had been complimenting Patient B's breasts because they looked good, and it was hard to ignore a patient who was almost 60 years old and had the breasts of a 30 year-old patient.

PATIENT C (Case # 2011-0357)

73. Patient C, a 21 year-old female, saw the Respondent for a termination of pregnancy on November 11, 2010.

74. A few days after Patient C's procedure, she filed a written complaint with the Board alleging that the Respondent had made an inappropriate sexual comment to her before her procedure.

75. On December 17, 2010, the Board's staff interviewed Patient C under oath and she testified that while she was on the examination table:

> [the Respondent] told me to put my legs up, and then he, was, like, oh you're very beautiful. You're going to have a lot of penises coming after you for a long time.

76. Patient C testified that she did not go back to the Respondent for follow-up care.

77. The Respondent submitted a written response to the Board stating that he did not recall the conversation he had with Patient C, but did not "intend" to do or say anything that would make her feel uncomfortable.

78. The Respondent's conduct, as outlined above, in whole or in part constituted unprofessional conduct in the practice of medicine in violation of Health Occ. § 14-404(a)(3) (ii).

C. PRESCRIBING TO FRIENDS/FAMILY MEMBERS AND SELF-PRESCRIBING

79. During the Respondent's interview under oath with the Board's staff on June 1, 2010, he testified that he prescribed Viagra to "guys that I've known for years."

80. The Respondent testified that he did not maintain a medical record for the Viagra prescriptions issued as it was a "curbside consult."

81. On or about April 22, 2008, February 21, 2009 and January 19, 2010, the Respondent prescribed Viagra; and on January 16, 2009 and January 19, 2010 hydrochlorothiazide (a diuretic) to Patient S, a male drug counselor with an office downstairs from the Respondent. Patient S had provided counseling to one of the Respondent's family members. The Respondent testified that he did not maintain a medical record for Patient S.

82. The Respondent prescribed Viagra to Patient T, his landlord, on September 28, 2006, which Patient T had filled at Pharmacy A on January 9, 2007, February 11, 2007 and April 18, 2007. The Respondent did not maintain a medical record for Patient T.

83. The Respondent prescribed Viagra to Patient U on or about October 20, 2006 with five refills, filled at Pharmacy A. The Respondent testified that he did not recall Patient U, when asked during his interview on June 1, 2010.

84. The Respondent prescribed Warfarin on December 12, 2006, multiple prescriptions for Propecia between August 2006 and November 2009 and Hydrocodone with APAP (with several refills) on February 24, 2007 to Patient V, a family member. He did not maintain a medical record for Patient V.

85. The Respondent prescribed Concerta, a Schedule II CDS, to Patient W on multiple occasions including the following dates in 2007: January 8, February 9, April 20, August 7; and in 2008: February 4, April 24, June 3, July 18, August 25, September 27, November 4, December 13; and in 2009: January 21, March 21,

July 28. Patient W was a member of the Respondent's immediate family and he did not maintain a medical record for him.

86. The Respondent self-prescribed several medications including Viagra, on September 9, 2006, April 9, May 3, June 8, 2007, July 2, 2008; Norvasc on March 24, 2007; Diovan on March 24, 2007 and July 2, 2008; Chantix on October 16, 2007 and Simvastatin on July 30, 2009.[10]

87. The Respondent's conduct, as outlined above, in whole or in part constituted unprofessional conduct in the practice of medicine in violation of Health Occ. § 14-404(a)(3) (ii).

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) and/or (40), 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 CASE RESOLUTION CONFERENCE

A Case Resolution Conference in this matter is scheduled for **May 2, 2012, at 10:00 a.m.** at the Board's office, 4201 Patterson Avenue, Baltimore, Maryland 21215. The nature and purpose of the case resolution conference is described in the attached letter to the Respondent. If this matter is not resolved

[10] Norvasc and Diovan are used in the treatment of high blood pressure. Chantix is used to assist in smoking cessation. Simvastatin is used in the treatment of high cholesterol.

on terms accepted by the Board, an evidentiary hearing will be scheduled.

1/20/2012
Date

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