IN THE MATTER OF	*	**BEFORE THE**
ROMEO A. FERRER, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D09255	*	**Case Number: 2008-0135**

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CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT

The Maryland State Board of Physicians (the "Board") hereby charges Romeo A. Ferrer, M.D. (the "Respondent") (D.O.B. 02/18/1941), License Number D09255, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2009 Repl. Vol.).

The pertinent provisions of the Act under H.O. § 14-404(a) provide as follows:

> **§ 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> 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:
>
> (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[.]

GENERAL ALLEGATIONS OF FACT[1]

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

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[1]The statements of the Respondent's conduct with respect to the patient identified herein 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.

1. At all times relevant hereto, the Respondent, who is board-certified in obstetrics and gynecology, was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on February 8, 1971.

2. At all times relevant hereto, the Respondent maintained an office for the practice of obstetrics and gynecology, "Gynecare Center," located at 877 Baltimore-Annapolis Boulevard, Severna Park, Maryland.

3. On or about August 24, 2007, the Board received from the Health Care Alternative Dispute Resolution Office a Claim Form filed by the estate of a twenty-one year old female, "Patient A,"[2] who had presented to the Respondent for an elective abortion procedure. The Claim alleged, *inter alia,* that the Respondent failed to properly administer pain medications, failed to properly monitor Patient A's respiration and ventilation during and after the procedure and failed to employ standard methods of care to resuscitate Patient A, resulting in Patient A's death. Thereafter, the Board initiated an investigation. The Board referred the matter to a peer review organization for review of the Respondent's practice in this case.

4. The peer reviewers opined that the Respondent failed to meet appropriate standards for the delivery of quality medical care for reasons including, but not limited, to those that are set forth below.

[2] The names of the patient and other individuals in this document are confidential. The Respondent may obtain the name from the Administrative Prosecutor.

Patient –Specific Allegations

5. On February 3, 2006, Patient A presented to Gynecare Center for a second trimester elective abortion procedure – a dilation and evacuation ("D&E") – at sixteen weeks gestation.

6. Patient A was healthy and her previous medical history was uncomplicated. Patient A's only known allergy was to penicillin. Her previous surgical history included two previous uncomplicated abortions and a missed abortion. She had one child, a three-year old son. On her health history form, it was noted that Patient A's reason for terminating her pregnancy was, "can't afford it right now." Patient A was accompanied to Gynecare by a female friend because she did not want her family to know about the abortion.

7. On February 3, 2006, Patient A signed a "Second Trimester Operative Consent" form in which she authorized the Respondent to perform a: "Suction abortion, D&C, or dilation and evacuation with such anesthesia and medication(s) as deemed necessary..."

8. During the Board's investigation, the Respondent advised Board staff that general anesthesia is not administered at Gynecare; instead, the Respondent administers "conscious sedation," sometimes referred to as "twilight sleep."

9. At or about 1:00 p.m. on February 3, 2006, the Respondent commenced the D&E using sonogram guidance.[3]

10. At 1:25 p.m., the Respondent administered 20 units of pitiocin, added to 500 cc of D5LR (5% dextrose in lactated ringer solution) through a 22 gauge catheter.

11. At 1:30 p.m., the Respondent administered by intravenous ("IV") push[4] 125 mg of Demerol[5] and 5 mg of midazolam.[6]

12. Five minutes later, at 1:35 p.m., the Respondent administered an additional 125 mg of Demerol and 5 mg of midazolam because "pt. was still reacting to pain..."

13. At 1:45 p.m., the Respondent completed the abortion.

14. The following notations were documented on an unlabeled lined form following the "Procedure/Recovery Room Record" form in Patient A's record:

> 1:47 p.m. – Surgical assistant [N.G][7]. noticed pts fingernail beds to appear blue in color
>
> 1:48 p.m. – [T.B.], NA unable to obtain BP [blood pressure] or pulse on pt. Second attempt to obtain BP & pulse by [T.P.], LPN. Pt accessed *(sic)*, Dr. Ferrer made aware.
>
> 1:49 p.m. – V.O. [verbal order] Narcan 0.4 mg IVP [IV push] by R.A. Ferrer, given via IV port by [T.B] NA

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[3] Unless indicated, all times and events are documented on Patient A's "Procedure/Recovery Room Record."
[4] An IV push, or bolus, refers the administration of medication into a vein in a short period.
[5] Demerol (generic name: meperidine) is a narcotic pain reliever.
[6] Midazolam (trade name: Versed) is a short-acting benzodiazepine used for inducing sedation and amnesia prior to medical procedures.
[7] In response to the Board's inquiry, the Respondent advised that the job titles of the employees involved in this incident were either "Medical Assistant" or "Licensed Practical Nurse (LPN)."

1:50 p.m. CPR given by R.A. Ferrer MD. Emergency crash medication opened by [T.P.]. CPR switch with Dr. Ferrer by [T.P.] & [T.B.]

1:51 p.m. – Epinephrine 1:10,000 intracardiac 1 mg given by R.A. Ferrer MD

1:52 p.m. – Dr. Ferrer resumed CPR from [T.P.] and [T.B.]

1:52 p.m. – [T.P.] called 911 operator and explained emergency. 911 operator assured paramedics has *(sic)* been dispatched and on their way to clinic.

1:55 p.m. – maintained open airway by head tilt chin lift & assessed compressions during CPR by R.A. Ferrer M.D. by [T.P.] & [T.B.]

2:00 p.m. – Paramedics arrived and took over care of pt.

15. When paramedics arrived at Gynecare, Patient A was unconscious and unresponsive. She was assessed as having pulseless electrical activity. Advanced cardiac life support attempts by the responding paramedics, including ventilation by oxygen mask and administration of atropine and Narcan, continued throughout Patient A's transport to the Anne Arundel Medical Center ("AAMC"); however, Patient A remained in asystole.

16. Upon arrival at AAMC, additional resuscitative efforts were attempted by the emergency room physician but were not successful.

17. Patient A was pronounced dead at 2:57 p.m.

18. The results of Patient A's autopsy revealed significant gross and microscopic evidence of pulmonary congestion and edema. There was no indication of any other underlying condition such as a cardiac condition, kidney disease, or evidence of maternal hemorrhage or a pulmonary and/or amniotic fluid embolism. The pathological diagnosis was "Meperidine Intoxication."

19. The peer reviewers opined that the Respondent failed to meet the standards of quality medical care in his treatment of Patient A for reasons including, but not limited to, the following:

20. **Failure to Appropriately Administer Anesthesia.** The Respondent administered by IV push an initial dosage of 125 mg of meperidine and 5 mg of midazolam. Five minutes later, he administered by IV push a second dosage of 125 mg of meperidine and 5 mg of midazolam; a total of 250 mg of meperidine and 10 mg of midazolam. The Respondent failed to meet the standard of quality care by not titrating the second dose of anesthesia; the second dosage was too large and administered too quickly.

21. **Failure to Provide Appropriate Intra and Post-Operative Anesthesia Monitoring.** On or about October 31, 1994, the Respondent issued a policy entitled "Sedation for First and Second Trimester Abortion Patients" which reads in pertinent part:[8]

> Effective on or around October 31, 1994, Gynecare Center will offer to all patients having local anesthesia, the option of conscious sedation. As ordered by the physician, the sedation will consist of but not limited to:
>
> 2.5 mg to 5 mg of Versed and 50 mg to 200 mg of Demerol combined together and diluted with 8 cc of sterile water. The dosage will be adjusted according to the patient's weight, response and state of consciousness. The patient's blood pressure and pulse will be monitored every 5 minutes. The pulse oximeter will be used at all times. Oxygen will be given by mask if oxygen saturation is below 85%, at the rate of 3 – 4 liters per minute.

[8] The Respondent provided this and other Gynecare policies in response to a Board subpoena directing him to produce a copy of protocols that were in effect on February 6, 2006 to include: conscious sedation, oxygen administration and monitoring during sedation, administration of IV general anesthesia & conscious sedation via titration and IV push, and resuscitation of patients who expire during abortion procedures and/or under general anesthesia or conscious sedation.

22. Contrary to the Respondent's policy regarding conscious sedation, Patient A was not monitored by pulse oximetry, nor was her pulse or blood pressure monitored every five minutes. Moreover, Patient A was not given oxygen supplementation. The Respondent's failure to monitor Patient A appropriately during and after the abortion constitutes a violation of the standard of quality care.

23. **Failure to Provide Adequate Resuscitative Efforts.** When the surgical assistant noticed at 1:47 p.m. that Patient A's fingernail beds were cyanotic, the Respondent attempted to establish an airway, but failed to give Patient A supplemental oxygen either through the use of an AMBU bag or any other form of nasopharyngeal airway.

24. The Respondent's conduct with regard to Patient A constitutes, in whole or in part, failure to meet the standard of quality care, in violation of H.O. § 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. Code Ann. §§ 14-404(a)(22), the Board may impose disciplinary sanctions against the Respondent's license, including revocation, suspension, or reprimand and may place the Respondent on probation, and/or may impose a monetary fine.

NOTICE OF CASE RESOLUTION CONFERENCE

A Case Resolution Conference in this matter has been scheduled for **Wednesday, June 2, 2010 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 and pre-hearing conference are described in the attached letter to the Respondent. If this matter is not resolved on terms acceptable to the Board, a hearing will be scheduled.

4/7/10
Date

John T. Papayasiliou
Deputy Director
Maryland Board of Physicians