COMMONWEALTH of VIRGINIA

Robert A. Nebiker
Director

Department of Health Professions
6603 West Broad Street, 5th Floor
Richmond, Virginia 23230-1712

www.dhp.state.va.us/
TEL (804) 662-9900
FAX (804) 662-9943
TDD (804) 662-7197

April 8, 2003

Craig S. Cropp, M.D.
4809 Jasmine Drive
Rockville, Maryland 20853

CERTIFIED MAIL
7160 3901 9844 6697

RE: License No.: 0101-058190

Dear Dr. Cropp:

This letter is official notification of the decision of the Informal Conference Committee ("Committee") of the Virginia Board of Medicine ("Board"), which met on April 4, 2003, in Richmond, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the Informal Conference Committee ("Committee") were: Cheryl Jordan, M.D., Chair; Harry C. Beaver, M.D.; and Dianne Reynolds-Cane, M.D.

After careful consideration, the Committee made the following Findings of Fact:

1. You were granted license number 0101-058190 to practice medicine in the Commonwealth of Virginia on July 13, 1998. Said license is currently active and will expire on March 31, 2004, unless renewed or otherwise restricted.

2. On November 30, 2000, Patient A, who suffers from insulin dependent diabetes, presented to your office for continued obstetrical care. You noted that the patient had edema and a proteinuria of 3+, up from 1+ on November 7 and 16, 2000. Despite her high risk for pregnancy-induced hypertension, you failed to perform a thorough evaluation of Patient A, and instead ordered a 24-hour urine collection and instructed Patient A to return in two (2) weeks. Karen Knapp, M.D., provided expert testimony to the Committee, stating that Patient A was at high risk for pre-eclampsia and should have been thoroughly evaluated for that condition at the November 30, 2003, office visit.

3. On December 3, 2000, you admitted Patient B to Pulaski Community Hospital, Pulaski, Virginia ("PCH"), with spontaneous rupture of membranes. Records indicate that during Patient B's delivery of her macrosomic infant (9lbs. 13oz.), you used vacuum

extraction, during which the vacuum was allowed to "pop" off approximately four (4) to seven (7) times. The repeated allowance of said "popping" is against sound medical judgment as it may cause cephalohaematoma, scalp lacerations and intracranial hemorrhage in newborns. Additionally, Patient B sustained multiple vulvar superficial tears and bruising; however, you noted in the medical record that there were "no problems." Dr. Knapp told the Committee that while your conduct was not outside the standard of care, it was not optimal care. Dr. Knapp stated that she would have prepared a detailed operative note in this type of case.

4. On January 16, 2001, you admitted Patient D to PCH due to abnormal uterine bleeding. Instead of evaluating Patient D through use of an endometrial biopsy, you performed a hysteroscopy and fractional dilation and curettage secondary to abnormal uterine bleeding. During the dilation procedure, you perforated the uterus at the anterior fundal surface to the left of the midline. You stated to the Committee that the perforation was an error that you made when you were distracted by your bifocals, and was only one of two perforations that had occurred during your career.

5. On January 19, 2001, you admitted Patient E to PCH for dilation and curettage for post-partum hemorrhage following a vaginal delivery on December 19, 2000, during which you ordered bolus administration of twenty (20) units of Oxytocin. During the January 19, 2001 procedure, you perforated the uterus in the fundus just left of the midline and anterior of the round ligament insertion. You performed a diagnostic laparoscopy followed by an open laparotomy. You failed to run the entire bowel to assess damage despite the Operative Report indicating a denuded peritoneum on the pelvic sidewall, the etiology of which was unexplained, and bowel injury, which was not well documented. Further, during Patient E's procedure, you left the operating room on two (2) occasions to confer with Patient E's husband. The Operative Report does not indicate that another physician was present in the operating room during your absences. Dr. Knapp stated to the Committee that an endometrial biopsy and other noninvasive measures may have benefited the patient. Dr. Knapp also stated that calling in a general surgeon would have been prudent in this case.

6. Based on your care and treatment of Patients D and E, your clinical privileges at PCH were summarily suspended on January 19, 2001. Effective on or about March 6, 2001, said clinical privileges were revoked.

7. You failed to update your Virginia Physician's Practitioner Profile to include the January 2001 summary suspension and subsequent March 2001 revocation of your membership on the medical staff of PCH due to the concerns of administrative staff regarding your clinical practice.

8. Dr. Knapp opined that you might not have sufficient experience in the procedures that you perform and would benefit from mentoring and practicing in a group setting. In her written report to the Committee dated June 30, 2002, Dr. Knapp stated, "there were a series of adverse outcomes that would prompt me to suggest oversight of [your] surgical activities."

9. You presented no documentation of continuing education hours in the last twelve (12) months, but stated that you have obtained some hours, none of which were interactive.

10. You stated to the Committee that you have not practiced medicine since January or February of 2002.

The Committee makes the following Conclusions of Law with regard to the above Findings of Fact:

1. Findings of Fact #2, 4, 5, 8 and 9 constitute violations of Sections 54.1-2915.A(3), as further defined in Section 54.1-2914.A(8) and (11) [*formerly Sections 54.1-2914.A(10) and (13)*] of the Code and Term 4 of the Board's Order entered November 2, 2000.

2. Finding of Fact #7 constitutes a violation of Section 54.1-2915.A(3), as further defined in Section 54.1-2914.A(11) and Section 54.1-2910.1 of the Code of Virginia (1950), as amended, Part VII of the Board's General Regulations, "Practitioner Profile System," and Term 4 of the Board's Order entered November 2, 2000.

3. Although the care given in the case of Patient B was not optimal, it did not rise to the level of being a violation.

Further, with regard to the Conclusions of Law deferred by the Board's Order entered November 2, 2000, the Committee concludes that Findings of Fact #4, 5 and 6, of that Order constitute violations of Section 54.1-2915.A(3), as further defined in Section 54.1-2914.A(8) and (11) [*formerly Sections 54.1-2914.A(10) and (13)*] of the Code.

Based on the foregoing findings of fact and conclusions of law, the Committee determined that revocation or suspension of your license may be justified and voted unanimously to refer this matter to a formal administrative hearing. Pursuant to Section 54.1-2919 of the Code, the Committee will present its findings to the Board and a formal administrative hearing will be scheduled to resolve this matter. You will receive written notice indicating the exact date, time and location of the hearing approximately thirty (30) days in advance of such a hearing.

Pursuant to Section 2.2-4023 of the Code of Virginia (1950), as amended, this case decision shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

Should you have any questions regarding the Committee's decision, you may refer them to Karen Perrine, Deputy Executive Director, Discipline, at (804) 662-7009.

Sincerely,

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

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cc: Harry C. Beaver, M.D., President, Virginia Board of Medicine
Robert A. Nebiker, Director, Department of Health Professions
Renee S. Dixson, Discipline Case Manager, Board of Medicine
Emily Wingfield, Assistant Attorney General
Sheon J. Rose, Senior Adjudication Analyst
Jennifer Baker, R.N., Senior Investigator (80129)
Patricia Hanchey, Administrative Assistant