



IN THE MATTER OF                   \*           BEFORE THE MARYLAND STATE  
ALAN J. ROSS, M.D.               \*           BOARD OF PHYSICIAN QUALITY  
                  RESPONDENT               \*           ASSURANCE  
LICENSE NO. D22050               \*           CASE NO. 92-0080

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MODIFIED CONSENT ORDER

BACKGROUND

On December 28, 1993, Alan J. Ross, M.D, ("Respondent") entered into a Consent Order with the Board of Physician Quality Assurance (the "Board").<sup>1</sup>

Pursuant to the terms of the Consent Order, the Respondent's license was SUSPENDED for a period of one year, the SUSPENSION was immediately STAYED, and the Respondent was placed on probation for a period of three (3) years from the date of the Consent Order. In accordance with the Order, the Respondent was required to comply with certain terms and conditions.

Condition 6 of the Order provides that the Respondent submit himself to the Focused Professional Education Committee ("FPEC") of the Medical and Chirurgical Faculty of the State of Maryland for evaluation and assessment for development of a medical education plan as determined by FPEC.

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<sup>1</sup>A copy of the December 28, 1993 Consent Order is attached and incorporated by reference.

FINDINGS OF FACT

On August 13, 1994, the Board received a copy of the report dated July 7, 1994 prepared by the FPEC. In the report, the FPEC addressed issues relative to the Respondent's current medical practice and provided several recommendations to assist the Respondent in delivering quality medical care to his patients.

On September 13, 1994, the Respondent met with the Board's Case Resolution Conference ("CRC") to discuss the findings of the FPEC. On this same date, the CRC also discussed with the Respondent his compliance with the remaining conditions of probation as set forth in the December 28, 1993.

With respect to Condition 5 of the Order, the Respondent informed the CRC that notification was given to the State Division of Laboratory Licensure that he no longer performs laboratory proficiency testing in his office.

The CRC resolved to recommend to the Board that each of the recommendations made by the FPEC be incorporated into the Respondent's practice by way of a modified consent order.

With respect to the other Conditions of probation, CRC determined that the Respondent has remained in compliance. The CRC further concludes that the language set forth in Condition 5 of the December 28, 1993 Consent Order regarding laboratory proficiency testing is no longer applicable.

CONCLUSIONS OF LAW

The Board incorporates by reference those Conclusions of Law set forth in the Consent Order dated December 28, 1993.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 26th day of October, 1994, by an affirmative vote of the majority of the full authorized membership of those members of the Board of Physician Quality Assurance, who considered this case, it is hereby

ORDERED that the Consent Order dated December 28, 1993 shall be modified as follows:

- (1) The Respondent shall attend weekly obstetrics/gynecology grand rounds at a teaching hospital;
- (2) The Respondent shall engage in a comprehensive obstetrics/gynecology review course twice yearly for the duration of his probationary period;
- (3) The Respondent shall utilize resources such as PROLOG and technical bulletins from the American College of Obstetricians and Gynecologists;
- (4) The Respondent shall obtain the services of a Board approved physician to serve as his supervising physician.
  - (a) The Respondent shall meet with the supervising physician on a weekly basis for at least a one year period from the effective date of this Order;

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(b) All costs associated with this supervision shall be borne by the Respondent;

(c) The supervisor shall submit quarterly written reports regarding the Respondent's practice of obstetrics/gynecology to the attention of the Board's Compliance Division. If at any time, the supervisor believes that the Respondent is a danger to his patients, is not competent to practice or is in violation of this Modified Consent Order, the supervisor shall immediately notify the Board;

(d) In the quarterly reports, the supervisor will also discuss whether the schedule for supervisory sessions should be continued or modified and whether the Respondent is fulfilling his financial obligations associated with the supervision;

(e) The Respondent shall disclose this Order to the supervising physician. The supervising physician shall submit to the Board in writing that he understands the terms of this Order, his/her responsibilities associated with the Order. In the event the designated supervising physician is unable to continue the supervisory relationship, Respondent shall disclose this Order to any subsequent supervisor approved by the Board, who shall submit in writing his/her understanding of the terms and responsibilities as set out in this Order;

(f) The Board must ratify any recommendation made by the supervisor before any change in the frequency of the supervisory sessions becomes effective;

(g) In the supervisory relationship, the Board approved supervisor shall be deemed a medical review committee and in this capacity shall be immune from civil liability pursuant to H.O. §14-412; and it is further

ORDERED the Respondent shall no longer be required to comply with the requirements of a proficiency testing service for laboratory proficiency testing as set forth in Condition 5 of the December 28, 1993 Consent Order; and it is further

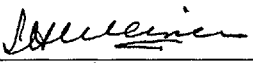
ORDERED the three (3) year period of probation ordered on December 28, 1993, hereby remains in effect; and it is further

ORDERED that all other provisions and terms and conditions of probation, contained in the December 28, 1993 Consent Order, shall remain unmodified and in full force and effect; and it is further

ORDERED that if the Respondent violates any of the foregoing terms and conditions of probation, as contained in the Consent Order dated December 28, 1993 and this Modified Consent Order, the Board, after notice and a hearing and a determination of a violation by a preponderance of the evidence, may impose any additional disciplinary sanction it deems appropriate; and it is further

ORDERED that this Modified Consent Order is a PUBLIC DOCUMENT pursuant to Maryland State Gov't Code Ann. §10-611 et seq.

10/26/94  
DATE

  
\_\_\_\_\_  
Israel H. Weiner, M.D.  
Chair

CONSENT

By this Consent, I hereby accept and agree to be bound by the foregoing Modified Consent Order and its conditions and restrictions, consisting of 5 pages.

I acknowledge the validity of the Modified Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right of counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protection provided by laws of the State of Maryland.

I acknowledge that I have had the opportunity to consult with counsel before entering into and signing this document.

I understand that if I fail to comply with any of the conditions of probation enumerated in this Modified Order, I may suffer disciplinary action against my license to practice medicine in the State of Maryland.

I understand that if I present a danger to the public, health, safety, or welfare, the Board, may, WITHOUT PRIOR NOTICE AND AN OPPORTUNITY TO BE HEARD, vacate the stay of the suspension, and reinstitute formal proceedings against my license to practice in Maryland.

I have had an opportunity to review this Modified Order with my attorney. I voluntarily sign this Modified Order understanding its meaning and effect.

10-17-94  
Date

Alan J. Ross, M.D.  
Alan J. Ross, M.D.

**EXHIBIT A**



IN THE MATTER OF \* BEFORE THE  
ALAN J. ROSS, M.D. \* STATE BOARD OF PHYSICIAN  
Respondent \* QUALITY ASSURANCE  
License Number: D 22050 \* Case Number: 92-0080  
\* \* \* \* \*

CONSENT ORDER

BACKGROUND

The State of Maryland Board of Physician Quality Assurance (the "Board"), charged Alan J. Ross, M.D. (the "Respondent") License Number D 22050, (D.O.B. 11/11/43), with a violation of the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §14-404(a)(22)(1991 Repl. Vol.), on October 23, 1992. The Board charged that the Respondent violated the following pertinent provision of H.O. §14-404 which provides:

(a) Subject to the hearing provisions of §14-405 of this subtitle, the Board, on the affirmative vote of a majority of its full authorized membership, 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 facility, office, hospital, or any other location in this State.

The Respondent was notified of these charges by personal service on July 13, 1993. A hearing was scheduled for this matter before the Office of Administrative Hearings on November 16, 1993.

On September 8, 1993, the Board held a Case Resolution Conference ("CRC"). As a result of the CRC's recommendations and the negotiations entered into between the Office of the Attorney

General and the Respondent, the Respondent agreed to enter into the following Consent Order according to the terms set forth below.

**FINDINGS OF FACT**

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. He was initially licensed in Maryland on June 8, 1978.

2. On December 10, 1991, the Board received a complaint in the form of a news release from Human Life International, regarding the death of a twenty-eight (28) year old woman (Patient A)\* after she had received an abortion on or about April 25, 1989 from the Respondent at the Respondent's office in Bethesda, Maryland.

3. On or about January 22, 1992, the Board referred the complaint for an investigation and an incident review to the Medical and Chirurgical Faculty of Maryland ("Med-Chi") Peer Review Management Committee (PRMC). Subsequently, Med-Chi PRMC referred this matter to the Montgomery County Medical Society (MCMS).

4. The MCMS Peer Review Committee (PRC) conducted an incident review, and then issued a report to the Board on March 3, 1992, finding that the Respondent failed to meet the standard of

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\*To ensure confidentiality, patient names are not set forth in this Charging Document. The Board maintains a list of patient names which corresponds to the alphabetical letter used in this document. This list is available to Respondent upon request.

care, as described in more detail below, and recommending a practice review.

5. Based upon the MCMS report, the Board ordered a practice review.

6. The Med-Chi PRMC again referred the matter to MCMS; thereafter, the MCMS-PRC conducted the practice review, including a site review which occurred on April 16, 1992 at the Respondent's office, located at 8311 Wisconsin Avenue, Bethesda, Maryland.

7. On August 14, 1992, the PRC of MCMS reported its findings to the Board. In its report, the MCMS-PRC found that the Respondent's overall practice was deficient and that the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care in several areas, inclusive of the following:

A. On or about April 25, 1989, Patient A presented to the Respondent for an abortion. The Respondent diagnosed Patient A as having an intrauterine pregnancy of six (6) to eight (8) weeks duration, and proceeded to perform a suction aspiration under local anesthesia. According to the Respondent's office records, the aspirate tissue obtained was abnormal, consisting of blood clots. After the abortive procedure, the Respondent sent Patient A home with a prescription for antibiotics.

On May 12, 1989, Patient A arrived in the emergency room of Greater Laurel Beltsville Hospital, in full cardiac arrest secondary to exsanguination, where she was pronounced dead.

Her death was caused by a ruptured tubal ectopic pregnancy.

A review of Patient A's office records indicated that the Respondent found the aspirate from Patient A's uterus to be grossly abnormal, containing mainly blood clots, although he never sent the specimen for pathological examination. According to the records and in a statement written to the Board dated January 6, 1992, the Respondent indicated that he detected placenta villi in the aspirated specimen, of six (6) weeks of pregnancy, by visual inspection.

The presence of placenta villi at six (6) weeks gestation is a microscopic diagnosis, one that is not made by visual inspection. Other than the visual inspection of the uterine aspirate, the Respondent performed no testing to confirm the diagnosis of intrauterine pregnancy. When a diagnosis of intrauterine pregnancy is not confirmed, the operating physician must further examine the patient with pelvic ultrasound, do pathologic examination of uterine aspirate, or do a serial HCG (Human Chorionic Gonadotropic) studies to determine if an ectopic pregnancy does exist.

In this case, the Respondent breached the standard of care with regard to Patient A when he:

- (1) did not consider an ectopic pregnancy when the uterine aspirate was found to be inconsistent with a six (6) to eight (8) week intrauterine pregnancy;
- (2) did not do serial HCG studies;

- (3) did not use pelvic ultrasound to rule out an ectopic pregnancy diagnosis;
- (4) did not send the uterine aspirate which was found to be abnormal for pathological examination; and
- (5) did not counsel Patient A as to the possibility of an ectopic pregnancy with its related risks and dangers.

B. During the on-site practice review, the peer reviewers examined patient medical records. In this inspection, the reviewers found that the Respondent's office records were grossly inadequate. All of the office charts were poorly documented and illegible. Due to the inadequate documentation, the records failed to demonstrate that the Respondent was delivering adequate medical care to his patients.

Of the records reviewed during the on-site practice review, none had a complete or comprehensive history or physical examination; none allowed for determination of the medical status of the patient; none was sufficiently detailed, or detailed at all, to permit another physician to continue treatment on the basis of the record; none had medication sheets; none had current or updated problem lists; none had any typewritten progress notes; none was legibly written -- all of the notes were handwritten, illegibly, by the Respondent who, during the on-site review, was unable to

translate his own writing. It is a breach of the standard of care to fail to maintain complete, accurate, and legible medical records which includes complaints, historical, physical, laboratory data, diagnosis and treatment plan, and medication lists.

C. The reviewers noted that the methods used for disposing of medical waste material were grossly inadequate. The Respondent disposed of all of his biologic waste, including used needles and gloves, and waste from terminations of pregnancies, in the regular trash. He maintained no separate contaminated biologic waste disposal.

D. While conducting the on-site review, the reviewers also noted that laboratory services (e.g. RH factor, chlamydia tests) were performed in the office laboratory; however, the Respondent had no proficiency testing for the tests being performed. When the reviewers queried the Respondent about proficiency testing, he indicated that this was not necessary since he did not charge the patients for the tests.

Overall, the reviewers concluded that the Respondent demonstrated a pattern of careless and inattentive medical care and failed to meet appropriate standards for the delivery of quality medical and surgical care.

**CONCLUSIONS OF LAW**

Based on the foregoing Findings of Fact, the Board concludes, as a matter of law that the Respondent failed 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 in violation of MD. HEALTH OCC. CODE ANN. §14-404(a)(22) (1991 Repl. Vol.).

**ORDER**

Based upon the foregoing Findings of Facts and Conclusions of Law, it is this 28 day of December, 1993, by the State Board of Physician Quality Assurance:

**ORDERED** that the Respondent's **LICENSE TO PRACTICE MEDICINE** in the State of Maryland be and it is hereby **SUSPENDED** for a period of **ONE YEAR**; and it is further

**ORDERED** that the suspension of the Respondent's license to practice medicine in the State of Maryland be and it is hereby **STAYED**; and it is further

**ORDERED** that the Respondent be and he is hereby assessed a fine in the amount of Twenty-Five Thousand Dollars (\$25,000.00); and it is further

**ORDERED** that the Respondent hereby shall pay the Twenty-Five Thousand Dollar (\$25,000.00) fine to the Board by certified check, payable to the "Maryland Board of Physician Quality Assurance," prior to the effective date of this Consent Order, that day being

the date the Board executes this Consent Order; and it is further

**ORDERED** that the Respondent be and he is hereby placed on **PROBATION** for a period of **THREE YEARS** from the effective date of this Consent Order; and it is further

**ORDERED** that the Respondent is subject to the following terms and conditions of probation for a period of three (3) years from the date of this Consent Order:

1. The Respondent voluntarily agrees to send out all abortive tissue and/or abortive aspirate and/or products of abortion for pathological examination. However, the Respondent acknowledges, understands and agrees that even though this provision is based upon a voluntary act, if the Respondent breaches this provision and fails to send out all abortive tissue and/or abortive aspirate and/or products of abortion for pathological examination, then this breach shall be deemed a violation of this Consent Order which shall be acted upon in accordance with the provisions in this Consent Order governing such violations.

2. The Respondent shall immediately separate his biologic waste from his regular trash and shall immediately use and maintain separate containers for, and separate methods of disposal of, biologic waste which shall be confirmed by the Board prior to the effective date of this Consent Order. The Respondent acknowledges and understands that it is his sole responsibility to adhere to, conform to and comply with applicable federal and state statutes regarding the separation and disposal of biologic waste. Nothing in this Consent Order can or shall be construed by the Respondent



as excusing, modifying, nullifying, altering or negating Respondent's statutory obligation concerning biologic waste.

3. The Respondent shall maintain complete and legible patient records, including in his charts a record of dates of visits; chief complaints; historical, physical and laboratory data; diagnosis, and a treatment plan; progress notes; communication of laboratory results to patients; types of tests; medications; and medical indications for prescribing medications and ordering diagnostic tests. The Respondent shall maintain patient records, complete and legible, that ensure continuity of health care by a subsequent health care provider.

4. The Respondent shall retain and use the services of a medical records transcriber or transcription service for records transcription and shall submit proof of the retention to the Board in writing on or before the effective date of this Consent Order. The written proof shall be in the form of an Affidavit signed by the Respondent and shall consist of the name, address and telephone number of the transcriber or transcription service.

5. The Respondent shall retain and use the services of a proficiency testing service for laboratory proficiency testing of laboratory services performed in the office laboratory and shall submit proof of the retention to the Board in writing on or before the effective date of this Consent Order. The written proof shall be in the form of an Affidavit signed by the Respondent and shall consist of the name, address and telephone number of the proficiency testing service.

6. The Respondent shall submit himself to the Focused Professional Education (FPE) program of the Medical and Chirurgical Faculty of the State of Maryland ("Med-Chi") for evaluation and assessment for development of a medical education plan as determined by Med-Chi FPE. The Respondent shall cooperate and adhere to any program, plan, medical education, education, training or course of study as determined by Med-Chi and shall pay the expenses associated with, and as determined by, the FPE program.

a. The Respondent shall CONTACT Med-Chi FPE and shall ARRANGE for and ATTEND the INITIAL EVALUATION with Med-Chi FPE WITHIN THREE (3) MONTHS after the effective date of this Consent Order and shall thereafter submit proof to the Board by way of written correspondence to the Board affirming that: (1) Respondent contacted Med-Chi FPE, stating the date; (2) Respondent arranged for an initial evaluation; and (3) Respondent attended the initial evaluation, stating the date.

b. The Respondent acknowledges, understands and agrees that the contacting of and reporting to Med-Chi FPE and submitting proof of same to the Board is the sole responsibility of the Respondent. The Respondent further acknowledges and understands that the three (3) month time period stated above shall not be changed, altered or extended, and that failure to contact and attend the initial evaluation as set forth above shall be deemed a breach of and violation of this Consent Order.

7. The Respondent shall be subject to periodic peer reviews during the period of probation as ordered by the Board, shall

cooperate in order to facilitate peer review, and shall participate in peer review where and when requested. The Respondent shall be subject to peer review on an annual basis, and shall be subject to a minimum of three (3) peer reviews as a condition of this Consent Order. The Respondent will receive a copy of each peer review report.

a. If, after conducting appropriate peer review of any kind, the peer review committee reports to the Board that the Respondent is not practicing within the standard of care, and if the peer review determination is approved and adopted by the Board, which has sole discretion in the matter, then this breach of standard of care shall be deemed a violation of probation under the terms of this Consent Order.

8. The Respondent shall practice competently. The Respondent shall practice within the standard of care as determined by appropriate peer review to be conducted as set forth in paragraph no. 7 above. If the Respondent is found to be practicing below the standard of care as determined by the Board through appropriate peer review, then he is deemed to have breached and violated the terms of his probation and this Consent Order.

**AND BE IT FURTHER ORDERED** that if the Respondent violates any of the terms of his probation as set forth in this Consent Order, then the Board, after determination of violation and notice and a hearing, shall lift the stay of suspension and reinstate the one (1) year suspension and/or impose any other disciplinary sanctions it deems appropriate, said violation of probation being proved by

a preponderance of evidence; and be it further

**ORDERED** that if the Board has probable cause to believe that the Respondent presents a danger to the public health, safety or welfare, the Board, **WITHOUT PRIOR NOTICE AND AN OPPORTUNITY FOR A HEARING, MAY VACATE THE STAY OF SUSPENSION AND REINSTATE THE SUSPENSION**, and/or impose any other disciplinary sanctions it deems appropriate, provided that the Respondent is given notice of the Board's action and an opportunity for a hearing within thirty (30) days after requesting same in accordance with State Government Article, of the Annotated Code of Maryland, Section 10-405; and be it further

**ORDERED** that three (3) years after the effective date of this Consent Order, the Respondent may submit a petition for termination of probation and reinstatement of his license without any conditions or restrictions to the Board provided that he has been peer reviewed a minimum of three (3) times; and be it further

**ORDERED** that the Respondent shall be responsible for all costs incurred under this Consent Order; and be it further

**ORDERED** that this Consent Order is considered a public document pursuant to MD. STATE GOV'T CODE ANN. §10-611 *et seq.* (1993 Repl. Vol.).

12/28/93

Date

*I. H. Weiner*

Israel H. Weiner, M.D., Chair  
Board of Physician Quality  
Assurance

**CONSENT**

I, ALAN J. ROSS, M.D., acknowledge that I am represented by legal counsel, and I have had the opportunity to consult with counsel before entering into and signing this document. By this consent, I hereby acknowledge that the Board, by clear and convincing evidence, could prove the Findings of Fact and Conclusions of Law contained herein. Accordingly, I accept and submit to the foregoing Consent Order, consisting of fourteen (14) pages.

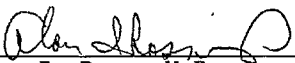
I acknowledge the validity of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the laws of the State of Maryland.

I acknowledge the legal authority and the jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order.

I also affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, without reservation, and I fully understand and comprehend the language, meaning, and terms of this Consent Order.

12/14/93  
Date

  
\_\_\_\_\_  
Alan J. Ross, M.D.  
Respondent

Read and approved:

12/14/93  
Date

W. Scott Sonntag  
W. Scott Sonntag, Esquire  
Attorney for Respondent

STATE OF MARYLAND  
CITY/COUNTY OF PRINCE GEORGE'S

I HEREBY CERTIFY that on this 14<sup>th</sup> day of DECEMBER,  
1993, before me, a Notary Public of the State and City/County  
aforesaid, personally appeared Alan J. Ross, M.D. and made oath in  
due form of law that the foregoing Consent Order was his voluntary  
act and deed.

AS WITNESS my hand and notarial seal.

Sandra A. Stain  
Notary Public

My Commission expires: JANUARY 1, 1995

ross#10.ord