IN THE MATTER OF	*	**BEFORE THE**
JOANNE B. KELLY, M.D.	*	**STATE BOARD OF PHYSICIAN**
Respondent	*	**QUALITY ASSURANCE**
License Number: D21467	*	**Case Number: 98-0486**

CONSENT ORDER

On or about September 8, 1999, the Board of Physician Quality Assurance (the "Board") charged Joanne B. Kelly, M.D. ("the Respondent") (D.O.B. 9/4/36), License Number D21467, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") § 14-404 (1994).

The pertinent provision of the Act under Health Occ. § 14-404 provides as follows:

> (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 surgical facility, office, hospital, or any other location in this State.

Respondent, through her attorneys, Wharton, Levin, Ehrmantraut, Klein & Nash David Levin, Esquire and Linda G. Wales, Esquire and Dawn Rubin, Assistant Attorney General, negotiated this proposed Consent Order for presentation to the Case Resolution Conference Committee of the Board on December 8, 1999.

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, Respondent was and is a physician licensed to practice medicine in the State of Maryland. She was initially licensed in Maryland on November 22, 1977, and her license is presently active.

2. At the time of the acts described herein. Respondent was a physician engaged in the practice of Anesthesiology at the Potomac Family Planning Center, 966 Hungerford Drive, Rockville, Maryland 20850.

3. On or about December 22, 1997, the Board received a complaint from the Rockville Volunteer Fire Department alleging that on December 20, 1997, an unresponsive female patient had not been appropriately monitored after an outpatient surgical procedure, and the medical staff had failed to initiate appropriate resuscitation. The patient expired the next day.

4. On or about December 31, 1997, the Board opened a full investigation, and on or about July 10, 1998, as part of its investigation, referred the matter to the Peer Review Management Committee ("PRMC") of the Medical and Chirurgical Faculty of Maryland "Med-Chi") for a review of the incident.

5. On or about July 13, 1998, the PRMC referred the case to the Montgomery County Medical Society ("Medical Society") for review. The Peer Review Committee of the Medical Society ("PRC") assigned two Board certified anesthesiologists ("peer reviewers") to review the case.

6. On or about October 9, 1998, the PRC submitted its report to the PRMC, concluding that the PRC and the peer reviewers concurred that Respondent did not

meet the standard of care with respect to the positive monitoring, treatment and resuscitation of Patient 1.[1] The PRMC submitted the report to the Board on or about October 22,1998.

7. As a result of the PRC's report, the Board found probable cause to charge Respondent with a violation of § 14-404 (a)(22) of the Act.

PATIENT 1

8. Patient 1 was a 27 year old female patient, who presented to the Potomac Family Planning Clinic for an elective Dilatation and Curettage ("D&C") by Dr. M,[2] for the purpose of terminating her pregnancy of six weeks. The, patient did not have a significant medical or surgical history. She had undergone a previous termination of pregnancy in 1995, under general anesthesia without complication.

9. Respondent initially met Patient 1 on the morning of December 20, 1997, prior to the procedure. After evaluating the patient, Respondent established an intravenous ("IV") line in anticipation of general anesthesia. The patient was connected to a cardiac monitor, a blood pressure monitor and a pulse oximeter. According to the Anesthesia record, Respondent administered the following anesthetic medications: 1 mg. Midazolam (Versed) (used for preoperative sedation and memory impairment of perioperative events); 75 mcg. Fentanyl (Sublimaze)(a narcotic agonist used for analgesic action of short duration during anesthesia); and 250 mg, Propofol

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[1]For purposes of patient confidentiality, the patients name will not be used in this charging document, but will be provided to Respondent.

[2]The Board also charged Dr. M with regard to this incident, and has issued a separate charging document.

(Diprivan)(IV sedative hypnotic agent used for the induction and maintenance of anesthesia or sedation) with Lidocaine.[3] During the procedure, Patient 1 maintained spontaneous respirations, and did not require positive pressure ventilation. The procedure, approximately five minutes in duration, was completed by Dr. M without incident.

10. After the procedure, Patient 1 was transferred at 10:10 a.m. to the Recovery Room (according to the documentation). She remained unresponsive, but was breathing spontaneously. The patient's blood pressure was documented as 112/60, and her heart rate as 103. An electronic monitor was used to obtain the patient's blood pressure. Nurse W administered oxygen to the patient, by mask. The patient was not connected to a cardiac monitor or pulse oximeter. After Patient 1's blood pressure was taken, another nurse (Nurse H) removed the cuff from the patient and placed it on a second patient where it remained for a period of time.

11. After Patient 1's transfer, Respondent went to another operating room to provide anesthesia to the next patient. She did not awaken Patient 1 prior to her transfer.

12. According to the documentation, at approximately 10:20 to 10:25 a.m., Nurse W noted that Patient 1 continued to remain unresponsive. Initially she requested that the nursing assistant present in the recovery room, retrieve some "Zoloft" (an antidepressant) from Respondent in the operating room, but then changed her request

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[3]Respondent changed the dosage of Diprivan with Lidocaine that she administered, in three subsequent statements. In a signed statement dated December 20, 1997, Respondent represented that she had given 200 mg. of Diprivan with 40 mg. of Lidocaine. In a signed statement dated December 23, 1997, Respondent represented that Patient 1, "really probably got 160 mg. of Diprivan because she was small." In Respondent's response to the Board dated January 23, 1998, she changed this amount again to reflect that 170 mg. of Diprivan with 3 cc of 1% Lidocaine were given.

to "Zofran" (an antiemetic). After making this request, a nurse went into the O.R. to request "Zofran" from Respondent, who was involved in an administration of anesthesia to another patient. Respondent gave the requested Zofran without evaluating Patient 1. There was no documentation in the record that the patient had experienced any nausea or vomiting while in the O.R.

13. According to the documentation, at approximately 10:25 a.m, Nurse W administered 2 cc of IV push Zofran to Patient 1. The patient remained unresponsive.

14. Shortly thereafter, Nurse W went back into the operating room to locate Respondent, who was still administering anesthesia to another patient. Nurse W requested another medication for Patient 1, Romazicon (reverses the sedative effects of benzodiazepines in cases where general anesthesia has been induced).[4] Respondent gave permission to Nurse W to administer the Romazicon to Patient 1, without evaluating her. Nurse W administered approximately 2cc of the medication IV push to the patient, who continued to remain unresponsive.

15. Shortly thereafter, Nurse H was replacing the blood pressure cuff on Patient 1, when she discovered that she was pulseless, and her pupils were "dilated". She summonsed Respondent, who was still in the operating room with another patient, to come evaluate the patient, which Respondent did immediately. Respondent found the patient unresponsive, and the record reflects her blood pressure was 60/40. Respondent started a second IV, and initiated cardio-pulmonary resuscitation. Initially, Respondent ventilated the patient with a pediatric sized Bag Valve Mask ("BVM"), the

[4]Patient 1 had received a small amount of Versed, which is a benzodiazepine.

only size BVM available on the crash cart that day.[5] Nurse H took over continuing to use the pediatric sized bag. Dr. M arrived, and according to his statement, helped administer IV medications. Respondent directed that the patient receive Epinepherine, Ephedrine and Lidocaine. Respondent failed to document oxygen saturation (patient was not hooked up to a pulse oximeter); cardiac rhythm or any other aspects of a physical examination including any respiratory rate, chest/heart auscultation, or neurological evaluation, although Respondent indicates the patient was hooked up to a cardiac monitor.

16. During this time, Dr. M ordered that someone on the staff call 911. According to the EMT records, 911 was called at 10:44, although the clinic records reflect this was done at approximately 10:30.[6] The paramedics from the Rockville Volunteer Fire Department arrived at 10:48 according to the EMT records, approximately 4 minutes later, and ascertained that the patient had suffered a cardiac and respiratory arrest.

17. The paramedics discovered the patient was being ventilated with a pediatric BVM. Respondent had not intubated the patient. The paramedics took control of the patient's care by intubating her, continuing resuscitation efforts with an Adult BVM, hooking the patient to a cardiac monitor defibrillator, defibrillating her; and administering narcan,[7] epinepherine and atropine IV push.

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[5]Dr. Kelly indicates the clinic, unbeknownst to her, had furnished a pediatric rather than adult sized BVM on their crash cart, which had previously been stocked with an adult mask.

[6]Consistently the clinic records reflect timing approximately 14 minutes different than that of the EMT clock, suggesting the two times cannot be accurately interchanged in analysis of this case.

[7]Narcan is a narcotic-agonist used in the reversal of narcotic-induced respiratory depression.

18. The paramedics transported the patient to Shady Grove Adventist Hospital by ambulance, and she arrived in the Emergency Room at approximately 11:09 a.m. On arrival, the attending physician in the ER noted that the patient's pupils were fixed and dilated, and there were no corneal reflexes noted. The ER staff carried out prolonged resuscitation efforts and eventually stabilized the patient's cardiac rhythm. The patient was transferred to the Intensive Care Unit. However, at approximately 4:15 a.m. on December 21st, Patient 1 expired.

19. Respondent failed to meet the standard of care with regard to Patient 1 for reasons including but not limited to her postoperative monitoring, treatment and resuscitation as follows:

A. Respondent's failure to assure adequate postoperative monitoring of Patient 1 in the recovery room including but not limited to: the, inappropriate administration of Zofran given under her direction, without appropriately evaluating the patient; the administration of Romazicon, given under Respondent's direction, without appropriately evaluating the patient; a lack of continuous blood pressure monitoring; no oxygen saturation monitoring (by pulse oximeter); and no postoperative cardiac monitoring;

B. Respondent's inadequate documentation regarding the resuscitative efforts of Patient 1, including no postoperative documentation of cardiac rhythm and oxygen saturation data;

C. Respondent's inappropriate use of a Pediatric BVM for an adult patient;

and

D. Respondent' s failure to intubate the patient.

CONCLUSIONS OF LAW

Based upon the above Findings of Fact, the Board concludes as a matter of law, that Respondent failed to meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical care in the State of Maryland, under Health Occ. § 14-404 (a) (22) (1994).

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is this 23 day of July, 2000, by a majority of the full and authorized membership of the Board considering this case,

ORDERED that Respondent's license to practice medicine in the State of Maryland be **SUSPENDED** for a period of three years, and be it further

ORDERED that the suspension be **IMMEDIATELY STAYED**; and be it further

ORDERED that Respondent be placed on **PROBATION FOR THREE YEARS** from the date of this Consent Order, subject to the following terms and conditions of probation;

1. Respondent shall immediately cease administering general anesthesia and may practice pain management in a Board approved setting with a Board approved supervisor until she successfully completes the following course-work:

A. A comprehensive Board-approved course of study such as a mini-residency in anesthesia that includes routine monitoring in anesthesiology, pharmacology in anesthesiology, emergency updates in anesthesiology, intubation techniques, and medical records documentation; and

B. A Board-approved course in emergency management such as an Advanced Cardiac Life Support ("ACLS") course offered by the American Heart Association. If the Board approves Respondent to take the ACLS course, Respondent shall receive ACLS certification at the completion of the course.

2. Respondent shall provide the Board with proof of course completion, and on completion may petition the Board for termination of Condition (1) of this Order. This petition for termination only applies to Condition (1), and shall not be construed to apply to any other term or condition in this Consent Order;

3. Should the Board approve Respondent's petition for the termination of Condition (1) of this Order, Respondent shall meet the following terms and conditions of this Order:

A. Respondent shall meet with a Board approved clinical supervisor/mentor who is Board certified in Anesthesiology twice monthly for at least one year, and shall engage in case discussions with the supervisor/mentor regarding all of Respondent's cases during the review

period, with the focus on perioperative and postoperative monitoring, anesthesiology coverage (peri and postoperatively), airway management, pharmacology and medical records documentation. Respondent shall ensure that the supervisor/mentor submit monthly written reports to the Board addressing the review of the above-referenced practice issues. Based on the reports, the Board in its discretion, may increase the frequency of the supervision/monitoring. If the Board receives any report from the clinical supervisor/monitor that in the discretion of the Board is unsatisfactory, the Board may require Respondent to appear before the Board[1] and the Board in its discretion may modify the conditions of probation. If the Board receives any report from the clinical supervisor/mentor that in the discretion of the Board Respondent has failed to deliver quality medical care, Respondent, shall be deemed to have violated the terms of her probation, and the Board, after notice and a hearing, and a determination of the violation, may impose any other disciplinary sanctions it deems appropriate, including lifting the stay of suspension, said violation of probation being proved by a preponderance of the evidence. If Respondent receives satisfactory reports from the supervisor/mentor for a period of one year from the date of this Conant Order, she may petition the Board for termination of condition (3)(A);

B. Respondent shall be subject to peer review or other review of

[1]This may take the form of a Case Resolution Conference.

records by the Board every six months and at the Board's discretion during the three years of probation. If the Board receives any report from the records review or practice review that in the discretion of the Board, Respondent failed to deliver quality medical care, Respondent shall be deemed to have violated the terms of her probation, and the Board, after notice and a hearing, and a determination of the violation, may impose any other disciplinary sanctions it deems appropriate, including lifting the stay of suspension, said violation of probation being proved by a preponderance of the evidence;

C. Respondent shall enroll in and successfully complete a comprehensive Board-approved course of study such as a Board review course that includes routine monitoring in anesthesiology, pharmacology in anesthesiology, emergency updates in anesthesiology, intubation techniques and medical records documentation on an annual basis during the term of this Consent Order, and shall provide proof of course completion to the Board;

D. Respondent shall be recertified in ACLS on an annual basis, and provide the Board with proof of her recertification;

4. The courses specified in paragraphs (1)(A), (1)(B), (3)(C) and (3)(D) shall not be used to fulfill Respondent's Continuing Medical Education requirements for licensure;

5. Respondent shall not violate any other provision of the Maryland Medical

Practice Act;

6. Respondent shall immediately notify the Board of her present place(s) of employment and position description(s), and in the event Respondent obtains further employment, or changes her employment in any way, she shall immediately notify the Board in writing of any new position description, and provide the Board with any new address and/or telephone number, and Respondent shall immediately notify all employers of the terms of the Consent Order;

7. There shall be no early termination from the terms and conditions of this Consent Order, with the exception of Condition (1) and (3)(A) should Respondent meet the terms and conditions as set out in paragraphs (1)(A) and (1)(B), and should the Board in its discretion grant the termination. After three years from the date of this Consent Order, Respondent may petition the Board for termination of the term and conditions imposed by this Consent Order (with the exception of Condition (1) and (3)(A) as set out in the previous sentence);

8. Respondent's failure to comply with any of the terms or conditions of this Consent Order shall constitute a violation of the Consent Order and it is further

9. **ORDERED** that Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

10. **ORDERED** that this Consent Order is considered a **PUBLIC DOCUMENT**

pursuant to Md. Code Ann., State Gov't § 10-611, et seq. (1995);

11. If Respondent violates any of the terms or conditions of the Consent Order, after notice and a hearing, and a determination of the violation, the Board may impose any other disciplinary sanctions it deems appropriate, said violation of this Consent Order being proved by a preponderance of the evidence. If Respondent presents a danger to the public health, safety or welfare of the citizens of Maryland the Board may summarily suspend Respondent's license under Md. Code Ann., State Gov't § 10226(c)(2)(1995).

2/23/10
Date

Sidney B. Seidman, M.D., Chair
State Board of Physician Quality Assurance

CONSENT OF JOANNE B. KELLY, M.D.

I, Joanne D. Kelly, M.D., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I admit to the Findings of Fact, and agree and accept to be bound by the foregoing Consent Order and its conditions and restrictions consisting of **15** pages. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

I acknowledge the validity of this Consent Order as if entered into 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 as provided by law. I acknowledge the Legal authority and the jurisdiction of the Board to initiate these

proceedings and to issue and enforce the 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 had an opportunity to consult with counsel, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order, and understand its meaning and effect.

Joanne B. Kelly, M.D.

12/8/99
Date

Reviewed by:

David Levin, Esquire — Date: 12/8/99

Linda G. Wales, Esquire — Date: 12/8/99

STATE OF MARYLAND
CITY/COUNTY OF:

I HEREBY CERTIFY that on this 8th day of December 1999 ~~2000~~, before me, a Notary Pubic of the State and County aforesaid, personally appeared Joanne B. Kelly, M.D., and gave oath in due form of law that the foregoing Consent Order was her voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Notary Public

My commission expires: 8-1-00

IN THE MATTER OF	*	**BEFORE THE MARYLAND**
JOANNE B. KELLY.	*	**STATE BOARD OF**
	*	**PHYSICIAN**
	*	**QUALITY ASSURANCE**
License Number: D21467	*	**BPQA Case No.: 2001-0630**

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ORDER FOLLOWING SHOW CAUSE HEARING

On September 18, 2002, the Board issued a charges of Violation of Probation against Dr. Kelly. At the same time, the Board issued a Notice of Show Cause Hearing regarding whether the stay of the suspension imposed in the previous Consent Order should be immediately lifted. Dr. Kelly appeared at a Show Cause Hearing on September 25, 2002. She requested a postponement at that time. The Board granted a postponement and issued an interim Order on September 27, 2002 placing restrictions on her license in the interim. Under these restrictions, Dr. Kelly was not permitted to perform anesthesia and was not allowed to prescribe Controlled Dangerous Substances. The Show Cause Hearing was postponed until October 23, 2002 and was held on that date.

After having considered the presentation at the Show Cause Hearing, the Board makes the following disposition regarding the proposed immediate lifting of the stay of the suspension.

1. It is hereby **Ordered** that the restrictions placed on Dr. Kelly's practice by the interim Order dated September 27, 2002 be lifted; and it is further

2. **Ordered** that a summary lifting of the stay of suspension will not issue at this time; however, should for any reason the evidentiary hearing on the merits not commence as scheduled on March 25 and 26, 2003, the Board will revisit the issue of a summary lifting of the stay; and it is further

3. **Ordered** that Dr. Kelly undergo an evaluation by both a psychiatrist and a neurologist chosen by the Board, at the Board's expense; the evaluators shall have access to the previous Consent Order, the current charges and the Peer Review report and shall report their findings directly and confidentially to the Board. *See* Md. Code Ann., Health Occ. § 14-402.

This Order of the Board is a public document. *See* Md. Code Ann., State Gov't § 10-617.

SO ORDERED this 4th day of November, 2002.

C. Irving Pinder, Jr., Executive Director