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Jan 24, 2011

IN THE MATTER OF	*	**BEFORE THE**
GIDEON M. KIOKO, M.D.	*	**MARYLAND BOARD**
Respondent	*	**OF PHYSICIANS**
License No.: D08283	*	**CASE NO: 2005-0499**

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ORDER FOR SUMMARY SUSPENSION
OF LICENSE TO PRACTICE MEDICINE

The Maryland Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of Gideon M. Kioko, M.D. (the "Respondent") (D.O.B. 11/21/39) license number D08283, to practice medicine in the State of Maryland.

The Board takes such action pursuant to its authority under Md. State Govt. Code Ann. ("S.G.") § 10-226(c)(2) (2004 Repl. Vol.), concluding that the public health, safety or welfare imperatively requires emergency action. The Board bases its conclusion on the following investigative findings after conducting an investigation.

INVESTIGATIVE FINDINGS

Based on the investigatory information obtained by the Board, including the instances described below, the Board has reason to believe that the following facts are true.

I. **Background**

1. At all times relevant hereto, Respondent was and is licensed to practice medicine in Maryland. The Respondent was originally licensed to practice medicine in Maryland on July 30, 1970 under license number D08283.

2. On or about August 2004, Respondent last renewed his license. Respondent's current license will expire on September 30, 2006.

3. Respondent also holds an active license to practice medicine in the District of Columbia.

4. Respondent currently maintains an office for the practice of obstetrics/gynecology ("OB/GYN") at 3311 Toledo Terrace, Suite C-105, Hyattsville, Maryland, 20782.

5. Respondent was granted Board certification in OB/GYN in 1975; and is not required to be re-certified.

6. At all times relevant to these charges, Respondent had hospital privileges at Prince George's Hospital Center ("Prince George's"), Cheverly, Maryland, having initially obtained these privileges in July 2001 and renewed in July 2003.[1]

II. Prior Board Case #s 1990-0253 and 1991-0030

7. On December 5, 1991, following issuance of public charges of violation of § 14-404(a)(3) immoral or unprofessional conduct, (18) practicing medicine with an unauthorized person, and (22) fails to meet of standard of quality care, the Board accepted Respondent's surrender of his license to practice medicine in Maryland. Respondent stated in the Letter of Surrender that his decision to surrender was based on an investigation of the Board that revealed the following:

[1] Respondent presently does not have privileges at Prince George's since he failed to complete the process for renewal and he resigned from the medical staff on July 23, 2005. George Washington University Hospital, effective July 30, 2003, denied Respondent clinical privileges on the basis of his failing to disclose on his application three medical malpractice cases, a licensure disciplinary action taken by the District of Columbia, and an affiliation with Providence Hospital. Respondent previously has held hospital privileges at Columbia Hospital for Women, which closed in approximately 2003, and Providence Hospital, both in Washington, D.C.

a. That during the period April 1989 through October 1989, I performed abortions at the Hillview Women's Medical Center ("Hillview"), located in Suitland, Maryland;

b. That during said period, unqualified individuals administered general anesthesia, in the form of intravenous Methohexital ("IV Brevital"), to patients before and during the course of abortions which I performed:

c. That two (2) patients, on July 12, 1989 and September 9, 1989, respectively, suffered cardiac arrests as a result of anesthesia complications during abortion procedures which I performed. As a result of the anesthesia complications described above, the patient who suffered a cardiac arrest on July 12, 1989 was pronounced legally dead on July 15, 1989; and the patient who suffered a cardiac arrest on September 9, 1989 sustained massive permanent brain damage[2];

d. That during the period February 1990 through the present, I have performed abortions at the CYGMA Health Center ("CYGMA"), located in Kensington, Maryland. I became Medical Director of CYGMA in November 1990;

e. That during said period, I have performed abortions in conjunction with a Certified Registered Nurse Anesthetist, who administers general anesthesia to patients during said procedures;

f. That during said period when general anesthesia was administered, neither an anesthesiologist nor a qualified licensed physician is physically present who has knowledge and experience in resuscitation, anesthetic drugs, and their reactions.

III. Prior Board Case # 1993-0288

8. On May 19, 1992, Respondent petitioned the Board for reinstatement of his license. On October 28, 1992, the Board voted initially to deny reinstatement. On January 29, 1993, Respondent requested a hearing on the denial.

[2] This patient subsequently died in a long-term nursing facility of complications from pneumonia approximately three years after the surgery.

9. A hearing was held beginning on August 29, 1994 and concluded on September 8, 1994.

10. Thereafter, on December 19, 1994, the Administrative Law Judge (the "ALJ") submitted to the Board a Recommended Decision. The ALJ recommended that Respondent's reinstatement be denied based on "his unimpressive CMEs and his lack of sincere remorse."

11. On July 21, 1995, following the receipt of Respondent's written Exceptions and a hearing on the Exceptions, the Board Ordered that Respondent's application for reinstatement be denied. The Board concluded that Respondent "has failed to demonstrate the ability to exercise sound medical judgment when an unforeseen emergency arises, or to prospectively identify potential situations which may evolve into emergencies." (Final Order, p. 19).

12. Thereafter, Respondent appealed the Board's decision to the Circuit Court for Prince George's County. On July 15, 1996, the Circuit Court reversed the Board's decision and remanded the case to the Board for additional proceedings.

13. On July 24, 1996, the Board requested that the parties make efforts to resolve the outstanding factual issues arising from the incidents at Hillview, since Respondent did not admit to the investigative findings in his Letter of Surrender. After lengthy negotiations between Respondent and the administrative prosecutor regarding proposed stipulations of fact, the parties appeared before the Board on April 23, 1997.

14. On May 28, 1997, the Board issued a Final Order and Opinion, incorporating the proposed stipulations of fact. Some of the Findings of Fact contained in the Order are as follows:

a. In a letter to the Board, dated March 29, 1990, Respondent described his role at Hillview and in the care delivered to the two patients as having "no responsibility for any postoperative complications." Final Order, p. 7;

b. Respondent failed to meet the appropriate standard of medical and surgical care, in part, because anesthesia was not administered by or under direct supervision of qualified personnel, Respondent did not ensure that the patients were appropriate candidates to receive IV anesthetic Brevital, did not ensure that the patients were appropriately monitored before and during the surgical procedures, did not ensure that vital signs were being appropriately monitored, did not ensure that proper medical equipment, resuscitative drugs, or qualified medical personnel were present to monitor patients and participate in resuscitative efforts if so required, did not perform a complete physical examination, and he performed surgical procedures under conditions that failed to meet appropriate standards for the delivery of quality medical and surgical care. Final Order, pp.10-14; and

c. From February 1990 to December 1991, Respondent performed abortions under local and general anesthesia, in conjunction with a CRNA in a health center in Kensington, Maryland. Respondent failed to meet the appropriate standard of medical and surgical care because he did not ensure that an anesthesiologist or qualified licensed physician was physically available to the CRNA for consultation at all times during administration of and recovery from anesthesia.

15. In its Opinion, the Board stated "Respondent's original misconduct demonstrated Respondent's serious lack of judgment regarding the administration of anesthesia and the obligation of a physician to insure the safety of patients undergoing surgical procedures. In particular, Respondent failed to recognize either the potential for emergency situations which might arise in the surgical setting or that he lacked the training and experience to respond appropriately." Final Order, pp. 17-18.

16. In deciding to reinstate Respondent's license, the Board focused on the "rehabilitative steps taken by Respondent to insure that events similar to those that led

to the surrender of his license will never recur ... that over time, Respondent has gained recognition of his responsibility for the tragic events at Hillview ... he has insured that the clinic where he practiced[3] has appropriate drugs and equipment for resuscitation ...Respondent became certified in Advanced Cardiac Life Support Resuscitation and now maintains his certification... Respondent appears truly remorseful and now comprehends that he is responsible for overseeing the well being of the patient." Final Order, pp. 18 - 20.

17. On May 28, 1997, the Board reinstated Respondent's license and placed him on probation for three (3) years subject to terms and conditions of probation, including annual peer review, prohibition on performing surgical procedures requiring general anesthesia or IV sedation unless performed in a hospital with an anesthesiologist present, prohibited from performing outpatient abortions after twelve (12) weeks gestation, and community service.

18. On October 29, 1997, the Board modified its prior Final Order stating that Respondent shall not perform outpatient abortions after eighteen (18) weeks of gestation.

19. On March 24, 1999, the Board terminated the probation based on Respondent's having complied with the conditions of probation.[4]

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[3] After the surrender of his license in Maryland in December 1991, Respondent continued to practice unrestricted in D.C. and maintained privileges at the Columbia Hospital for Women. Final Order, p. 18.

[4] On June 17, 2002 and May 7, 2003, Respondent submitted a statement to the National Practitioner Data Bank ("NPDB") stating that the NPDB report is "in dispute." Respondent stated that the allegations of the Maryland Board arising from the events of September 1989 were proven wrong and untrue, that he has had unencumbered licenses in D.C. and MD, and he was "vindicated by court of law."

IV. Prior Disciplinary Action in the District of Columbia

20. On March 6, 1996, the District of Columbia ("D.C.") Board of Medicine, placed Respondent's license to practice medicine in D.C. on probation for sixty (60) months, with conditions, because he "acted in a professionally incompetent manner; aided an unauthorized person in the practice of medicine; disregarded the health, welfare, and safety of a patient; and failed to conform to prevailing standard of acceptable medical care." The conditions included a $5000 fine, prohibition on performing any abortions in D.C., performance of community service, and completion of programs in "cultural diversity and sensitivity training on female issues."

21. On June 5, 1996, at Respondent's request, the D.C. Board amended the prior order to remove a prohibition against abortions, and added practice monitoring and a malpractice insurance requirement.

22. On June 30, 1999, at Respondent's request for early termination based on termination of probation in Maryland, the D.C. Board terminated Respondent's probation and restored his license to "unencumbered" status.

V. Current Maryland Case # 2005-0499 – Background Investigative Findings[5]

23. On January 13, 2005, the Board received a complaint from the Risk Manager at Washington Adventist Hospital stating that on December 1, 2004, a 26 year old female (Patient A[6]) was admitted to Washington Adventist Emergency Room by way of ambulance after an incomplete abortion performed in the office of Respondent on

[5] The statements of Respondent's conduct described herein are intended to provide notice of the basis of the suspension. They are not intended as, and do not necessarily represent, a complete description of evidence, either documentary or testimonial, to be offered against Respondent with regard to this matter.

[6] To preserve confidentiality, patient names are not used in this document, but will be provided to Respondent. Respondent is aware of the identity of the two patients cited herein.

December 1, 2004. The complainant stated, "The patient hemorrhaged and developed disseminating intravascular coagulopathy." The complainant further stated, "On admission, she underwent the following procedures: exploratory laparotomy, repair of uterine perforation, bilateral uterine artery ligation, right utero-ovarian artery ligation, repair of cervical laceration and repair of vaginal vault laceration. The final pathology diagnosis of the uterine contents included the fetal head and upper vertebral column. The patient was discharged on December 6, 2004."

24. Thereafter, the Board opened an investigation.

25. On February 12, 2005, at the request of the Board, Respondent submitted to the Board the complete medical records of Patient A and his response to the complaint.

26. In or about early April 2005, the Board received an anonymous telephone complaint from a female from a hospital regarding a "botched abortion" performed by Respondent. No other information was provided.

27. Thereafter, on April 19, 2005, the Board received by facsimile, the first page of the Board's complaint forms identifying Respondent and identifying a patient, Patient B, with dates of service from 1/29/05 to 2/6/05. Other than the words "confidential " and "anonymous," there was no further information provided.

28. The Board combined its investigation of the second complaint in regard to Patient B with the first complaint.

29. On June 8, 2005, at the request of the Board, Respondent submitted to the Board his response to the second complaint regarding Patient B.

30. On September 9, 2005, Board staff interviewed Respondent in regard to the two complaints.

31. On October 5, 2005, Board staff went to Respondent's office to serve a subpoena for personnel records for all employees from 2003 to present. Respondent was present while Board staff conducted a site visit.

32. On October 13, 2005, Board staff, including a medical consultant to the Board who is OB/GYN specialist, returned to Respondent's office and conducted a second site visit. Respondent was not present.

33. On October 17, 2005, the Board requested that a board-certified OB/GYN (the "physician reviewer") conduct a review of Respondent's practice. The physician reviewer based her review on documents relating to the Board's investigation, including Respondent's office records of Patients A and B and the hospital records of Patients A and B.

VI. Current Maryland Case # 2005-0499 – General Investigative Findings

A. Office and Equipment

34. Respondent rents an office in Hyattsville, Maryland on a part-time basis from a dermatologist, where Respondent performs outpatient abortions, including second trimester abortions[7], and has an ambulatory GYN practice.[8]

[7] The first trimester is up to 12 weeks gestation and the second trimester is from 12 to 22 ½ weeks gestation.

[8] Respondent stated that he stopped having an obstetrics practice two years ago due to high malpractice premiums.

35. According to Respondent's office staff, Respondent performs one to three terminations of pregnancy procedures a week[9] and sees ambulatory GYN patients, including older patients for hormone replacement therapy.

36. Respondent's office consists of two examination rooms, an office, storage area, closet with dermatological samples, and a bathroom. One examination room is used for termination of pregnancies and GYN examinations. In the room was a sonogram machine, aspiration machine, standard GYN examination table, sterile specula, sink, and sharps[10] container. The carpeting was stained and unclean.

37. The aspiration machine consists of a section of tubing that goes from the machine into a glass receptacle and another section of tubing that goes from the receptacle and is attached to a cannula that is inserted into the patient. Office staff stated that Respondent does not use a new sterile aspiration tube for each patient. The tube is used throughout the day and then washed and reused until it becomes opaque and then it is discarded.

38. An ultrasound machine is in the procedure room, however the printer has not worked in a while, hence no hard copies are obtained. Respondent did not have a crash cart in the office.[11] Respondent did not have any laryngoscope and endotracheal

[9] Respondent states he performs between two to four termination of pregnancy cases a month.

[10] A "sharp" is defined as a syringe, needle, surgical instrument, or other article that is capable of cutting or puncturing human skin. Md. Regs. Code tit. 26, §13.11.02B(8).

[11] "Crash cart" is a slang term for emergency resuscitation equipment including emergency medications such as epinephrine, an ambu bag, and endotracheal tubes, equipment necessary for advanced life support and CPR (cardiopulmonary resuscitation).

tubes[12], oxygen equipment including ambu bag[13], facemask, nasal tubing, and oxygen cylinders, or red biohazard bags in view.

39. On the second site visit, on October 13, 2005, office staff informed Board staff that the "crash cart" consisted of an empty capped syringe and two vials of epinephrine. These items were in a rubber examination glove and taped to the wall of the procedure room.

40. The office does not have a policy or procedure manual for emergencies, such as significant bleeding.

41. The other examination room contained an examination table and cabinets containing IV fluids. This other room is used as a recovery room.

42. The storage area contained an examination table and autoclave. There were samples of medications and birth control pills on an open shelf.

43. There is a small laboratory with a hema-Q machine for obtaining hematocrits. Respondent obtains Rh typing but does not obtain blood typing.

44. Respondent informed Board staff that he does not keep appointment logs, and patient sign-in sheets are destroyed the day of the appointment for "confidentiality" reasons.

B. <u>Office Personnel</u>

45. According to office staff, Respondent has three employees: his wife[14], his niece, reportedly a nursing student, who occasionally is a receptionist, and a medical

[12] A laryngoscope and endotracheal tubes are used to intubate a patient in respiratory distress.

[13] An "ambu bag" is used for resuscitation.

assistant/office secretary who works part-time in the morning for two or three hours.[15] Respondent has employed the medical assistant/office secretary since April 2005. The medical assistant/office secretary was not aware if Respondent has hospital privileges.

46. The medical assistant/office secretary obtains vital signs, performs finger sticks for hematocrit, sterilizes equipment, assists in procedures by handing Respondent KY jelly and applying Betadine, and cleans the office after procedures.

47. According to office staff, Respondent's wife assists with the procedures when the medical assistant is not working.

48. According to Respondent's wife, she does not work for Respondent.[16] She is employed fulltime as an administrator of a home health agency. Respondent's wife reported that she occasionally assists with filing, phone coverage, and office duties in the evening or on Saturdays. Respondent's wife reported that on occasion she has assisted with preparing a patient for a termination of pregnancy procedure, which she would chart and sign as the assistant. Respondent's wife stated that she is an RN licensed in Maryland, but was unable to provide Board staff with the number.[17]

49. There are at times only two people in the office besides the patient; that is, Respondent and the medical assistant/receptionist. There are no patients on Mondays, one or two patients for termination of pregnancies on Wednesdays and Thursdays, and GYN patients on Saturday morning.

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[14] Respondent reported to Board staff that his wife is an RN; however, Respondent's wife in not licensed by the Maryland Board of Nursing as an RN, or in any other licensure status.

[15] On or about October 16, 2005, Respondent terminated the medical assistant/secretary.

[16] Board staff interviewed Respondent's wife telephonically.

[17] See footnote 14.

C. **Termination of Pregnancy Procedures**

50. According to office staff, Respondent performs ultrasound on most patients to determine gestational age. As noted above, the printer has not worked for "a while;" therefore, no hard copies are obtained.

51. According to office staff, Respondent makes a determination of biparietal diameter and crown length, but Respondent does not always document this information.

52. Respondent informed Board staff that he obtains a medical history from all patients, but he does not always document the history. Respondent reported to Board staff that he does not perform physical examinations except if the patient presents with a significant medical history. Respondent reported that he performs a pelvic examination on all of his patients.

53. According to office staff, Respondent does not always complete the history and physical form.

54. According to office staff, when Respondent performs a termination of pregnancy procedure, the patient has an initial blood pressure taken, is placed on the table with a drape across her abdomen and legs, Respondent preps the perineum with Betadine, inserts a speculum upon which "KY" jelly from an unsterile tube has been applied, and then exposes the cervix. Respondent uses a cotton swab dipped in Betadine to clean the cervix. Respondent then performs a paracervical block. According to office staff, patients do not receive any type of sedation, intravenous anesthesia, conscious sedation, or general anesthesia.

55. If there is increased bleeding, Respondent administers Pitocin intramuscularly or Methergine transvaginally into the cervix.

56. After the termination of pregnancy procedure, the patient is walked to the "recovery room" and one blood pressure is taken. Respondent checks the patient in an hour to be assured there is adequate hemostasis, that is, that the patient has stopped bleeding.

57. Respondent provides the patient with a prescription for an antibiotic, usually Doxycyline.

58. The patient is given a printed sheet with instructions and is seen by Respondent for follow-up in two weeks.

59. Respondent does not send any tissue to a laboratory for pathological evaluation.

D. Violations of CDC Guidelines on Universal Precautions, Federal and State Occupational Safety and Health Standards, and General Infection Control [18]

60. There were no Center for Disease Control ("CDC") guidelines posted in the office.

61. The office carpet was stained and unclean.[19]

62. Tubing on the aspiration machine that is attached to the cannula and inserted in the patient is used throughout the day and then washed and reused on

[16] The CDC guidelines on universal precautions are contained in the Code of Federal Regulations, Title 29 by the Occupational Safety and Health Administration (OSHA) and incorporated in the Maryland Occupational Safety and Health (MOSH) standards.

[19] 29 CFR §1910.1030(d)(4)(i) requires employers to ensure that the worksite is maintained in a clean and sanitary condition.

subsequent days until it becomes opaque and then it is discarded. When the suction is broken, the contents in the tubing may be reinserted in the patient.[20]

63. The sharps container was full and sitting on the floor in the procedure room, not attached and locked to the wall.[21]

64. Respondent does not have a contract for removal of biohazardous material, particularly the aspirated contents of the uterus[22] and bloody sheets.[23] Respondent places the materials in a red bag and personally disposes of it. Office staff did not know where.

65. Respondent does not maintain a log for when and how much bio-hazardous material is picked up.

66. There were no policy or procedure manuals regarding cleaning and/or sterilization techniques for instruments and equipment in order to ensure that decontamination procedures are conducted appropriately.[24]

67. In Respondent's office, a refrigerator, located in the area by the receptionist, contained Rhogam[25] and dermatological medication medicine, along with food, opened soda bottles, and opened condiments.[26]

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[20] 29 CFR §1910.1030(b) defines "other potentially infectious materials" as including vaginal secretions, amniotic fluid, and any body fluid that is visibly contaminated with blood.

[21] 29 CFR §1910.1030(d)(4)(iii)(A)(2) requires that during use containers for sharps shall be maintained upright throughout use.

[22] 29 CFR §1910.1030 (d)(4) (iii) pertains to requirements for handling "regulated waste," defined in part as liquid or semi liquid blood or other potentially infectious materials.

[23] 29 CFR §1910.1030(d)(4)(v) pertains to proper handling of contaminated laundry.

[24] 29 CFR §1910.1030(g) pertains to communications of hazards to employees and requires information and training.

[25] Rhogam is a medication used to prevent sensitizing an RH- mother to an Rh+ fetus.

E. **Emergency Back Up**

68. Since July 23, 2005, Respondent does not have hospital back up for the outpatient abortions that he performs since he does not hold any hospital privileges.

69. If there is an emergency, Respondent calls "911" and the patient is taken to the nearest hospital.

F. **Board's Preliminary Response**

70. On October 13, 2005, the Board hand-delivered correspondence to Respondent advising him to immediately cease and desist from performing any and all abortion procedures until the Board's investigation is resolved.

71. On October 16, 2005, Respondent informed the Board in writing that he has purchased an "emergency kit", he was in the process of hiring a physician's assistant, and he took a course in CPR to update his certificate.[27] Respondent also stated that he terminated his medical assistant because he suspected her of taking office funds.

VI. Patient Specific Investigative Findings

Patient A

72. On December 1, 2004, Patient A, a twenty-six (26) year old female (d.o.b.10/18/78) presented to Respondent's office at 9:00 a.m. for a termination of pregnancy procedure. Other than Respondent, no one else was present in the office. Respondent telephoned someone to come to the office.

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[26] If medication drops into an open food container, it is not possible to ensure that the medication is sterile.

[27] Respondent submitted to the Board a card from the American Heart Association stated he has completed Basic Life Support training for healthcare providers.

73. Patient A informed Respondent that she believed she was four (4) months pregnant.

74. Respondent performed a sonogram and informed Patient A that she looked more than four months pregnant.[28] Patient asked if there would be any problems and Respondent stated there would not be.

75. Initially, during the investigation, Respondent reported to the Board that he did not obtain a sonogram on Patient A because the electrical power had gone out.[29]

76. Later, during the investigation, Respondent stated Patient A was about 19 to 20 weeks gestation, based on a sonogram that Respondent performed in his office. Patient A's medical record in Respondent's office did not contain a sonogram or documentation of fetal measurements.

77. Respondent then stated that sometimes the sonogram does not print if it is out of paper, but Respondent did not recall if that occurred in this case.

78. An unidentified young female presented and took Patient A's vital signs.

79. Respondent did not perform any blood work on Patient A, including Rh factor and hematocrit.

80. According to Patient A, at approximately 10:00 a.m., Respondent started an IV and gave Patient A Motrin.

81. During the aspiration procedure, the office electricity was going "on" and "off."

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[28] It was subsequently determined, based on the circumference of the fetal head that Patient A was at least 5 months pregnant. See paragraph 96.

[29] According to Respondent, the "power failure" occurred after he had begun the abortion procedure. Respondent acknowledged during the investigation that if a sonogram were taken, it would have been taken before the procedure began.

82. Respondent stated that he began the procedure at about 11:30 a.m. and that during the procedure, while he was aspirating, there was "power failure" for about an hour.

83. Patient A reported that around noon she started to feel dizzy and hot and asked for her cell phone to call her emergency contact but Respondent refused to give it to her. Patient A stated she "begged" Respondent to call her contact but Respondent would not do so.

84. Respondent then resumed the procedure at approximately 2:00 pm. Respondent stated he was able to remove the placenta but was unable to remove the head. Respondent reported that Patient A started bleeding profusely.

85. According to Patient A, Respondent informed Patient A that he would have to "cut the baby up" to get it out but he was unable to get the head out.

86. Respondent stated that Patient A's bleeding continued.

87. Patient A reported that she told Respondent to call "911" because she could not breathe and kept "passing out." Patient A reported that her blood pressure was not taken after the initial reading.

88. Respondent stated he called his wife who came to his office from her place of employment to assist.[30] Respondent's wife took vital signs, including blood pressures, and observed Patient A.

89. At 3:50 p.m., Respondent called 911 stating that a female is having an abortion, is bleeding profusely, semi-conscious, breathing, unknown if blood thinner

[30] Respondent's wife has no recollection of being called by Respondent to assist with a patient who was having problems with bleeding.

disorder. Respondent stated to Board staff that he requested that Patient A be transported to Prince George's Hospital.[31]

90. A Prince George's County Fire Department ambulance arrived at Respondent's office at 3:55 p.m.

91. According to the Maryland Ambulance Information System ("MAIS") report, upon arrival, the emergency personnel heard a woman screaming from the back of the office. Respondent met the personnel and stated that the patient was bleeding heavily and that the baby's head was still inside. Respondent stated that the heavy bleeding had begun over an hour previous and that Patient A may have D.I.C. ("Disseminated Intravascular Coagulation.") [32]

92. Emergency personnel entered the room where Patient A was located. The MAIS report noted:

> Female pt. naked from the waist down and rolling back and forth on the table, screaming. Pt. covered in blood, legs bathed in blood, heavy constant stream of blood spurting from pt's vagina, table covered in blood numerous equipment tools on tables covered in blood. Suction unit on table also covered in blood and had blood init. Pt. had an IV line started by on scene office personnel. IV bag also covered in blood.
>
> Pt. responded to her name but could not answer questions. Moaning and screaming. Pt. Stopped moving. Female attendant on scene tried to arouse pt. No response. (emergency personnel) slid onto cot. Pt. awake as being moved & responded by screaming again.

93. The emergency personnel transported Patient A to Washington Adventist Hospital ("Adventist"), the closest emergency department.

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[31] At the time, Respondent had privileges at Prince George's.

[32] Disseminated Intravascular Coagulation is a life-threatening bleeding disorder.

94. Patient A arrived at Adventist at 4:09 pm. On arrival, her hematocrit was 12.5, Hemoglobin 4.2; she was in shock and likely in DIC.

95. Patient A underwent emergency laparotomy by the on-call GYN. The surgical findings were: uterine perforation, cervical lacerations, vaginal lacerations, retained fetal skull and vertebral column. The procedures performed were: exploratory laparatomy, repair of uterine perforation, repair of bilateral uterine artery laceration, repair of two cervical lacerations, repair of vaginal vault laceration, transfusions, and estimated blood loss of 400 cc. Patient A was taken to the emergency room in "guarded condition."

96. Final pathology of the uterine contents included a fetal head of 17.5 cm and upper vertebral column, placing the gestational between 20.5 and 22 weeks.[33]

97. Patient A was discharged to home on December 6, 2004, in a stable condition.

Patient B

98. On January 29, 2005, Patient B, a thirty year old female (d.o.b. 6/10/74) presented to Respondent on referral from Potomac Family Planning. Patient B completed an intake form on which she noted that she had three previous pregnancies, which resulted in two abortions and one miscarriage. Patient B did not complete the portion of the form regarding allergies, current medications, or history of medical conditions.

99. Respondent did not document any gynecological history regarding Patient B, including the dates of the previous pregnancies and procadures.

[33] Based on this gestational age, Patient A was at least 5 months pregnant.

100. During the investigation, Respondent reported that he does not always document a history and physical.

101. Respondent documented a pelvic examination and noted that the gestational age of the fetus was 18+ weeks. Respondent reported to Board staff that he determined the fetal age by sonogram that he performed in his office. Respondent, or his medical assistant, documented Patient B's vital signs.

102. Patient B's medical record in Respondent's office did not contain a sonogram or documentation of fetal measurements.

103. Later, Respondent reported to Board staff that Patient B brought a sonogram with her from another physician.

104. Respondent documented that he performed a para-cervical block using xylocaine. The cervix was grasped, and then dilated and a 16 mm suction tip was used to aspirate the uterine contents "with difficulty." Respondent reported that he suspected uterine perforation and possible bowel injury.

105. Respondent documented that the procedure was terminated at about 3:00 p.m. and that Patient B was transferred to Prince George's.

106. According to records from Prince George's, Respondent transported Patient B to the hospital in his own car. Respondent did not call "911."

107. Patient B presented to Prince George's at approximately 7:00 p.m. with uterine perforation.[34]

[34] There is no explanation for the four-hour gap between when Respondent terminated the procedure and when Patient B presented to the emergency department.

108. In his operative report at Prince George's, Respondent stated, "(D)uring aspiration it became apparent that there was a uterine perforation and possible bowel injury. The procedure was immediately terminated."

109. Respondent requested a surgeon to assist with Patient B because he suspected a bowel injury. The surgeon's post-operative report states that his post-operative diagnosis is "perforated uterus, with transaction of rectosigmoid colon and extensive lacerations of the left colon and upper rectum and perforated urinary bladder." The surgeon performed a left colectomy with colostomy[35] and repair of the urinary bladder perforation.

110. Respondent performed exploratory laparotomy, hystecotomy, myomectomy[36], removal of fetus and placenta and repairs to the uterus.

111. Patient B was discharged to home from Prince George's on February 6, 2005.

VII. Summary Regarding Emergency Action

112. The above investigative facts regarding Respondent's office conditions and procedures and Respondent's case and treatment of Patients A and B, constitute extraordinary circumstances, requiring immediate suspension of Respondent's license to practice medicine under Code Md. Regs. tit. 10, § 32.02.05B(7).

113. Based on the review by the Board's experts, the facts that imperatively require emergency action, including but not limited to the following, are that Respondent:

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[35] Under these circumstances, a colostomy is not reversed until four to six months later.

[36] A myomectomy is an elective procedure to remove uterine fibroids.

a. Fails to sufficiently monitor patients in that he performs outpatient abortions without adequate number of qualified personnel available to assist while he is performing the procedure, to monitor the patients at the conclusion of the procedure, and to assist in an emergency;

b. Performs abortions without obtaining a medical history and an adequate physical examination;

c. Fails to sufficiently document preoperative assessments of patients undergoing abortions;

d. Performs outpatient abortions under local anesthetic without knowing whether the procedure may safely be performed by documenting the size of the fetus;

e. Performs outpatient abortions without emergency resuscitative equipment, including an ambu bag, IV set-up, laryngoscope, endotracheal tubes, epinephrine, benydryl, and oxygen cylinders;

f. Performs outpatient abortions without having an office policy or procedure manual for emergencies, such as significant bleeding;

g. Performs outpatient abortions without emergency back-up by having privileges at a near-by hospital or having a contract with another physician who has privileges at a near-by hospital;

h. Fails to maintain a sterile field while performing an abortion by reusing the aspiration tube for successive patients;

i. Fails to maintain a sterile field while performing abortions by reusing aspiration tubes until they are opaque;

j. Fails to maintain a sterile field while performing abortions by using KY jelly from an unsterile tube;

k. Fails to monitor patients after abortions by checking the patients' respiration, pulse, and blood pressure every 15 minutes;

l. Inappropriately administers oxytocic agents, such as Pitocin, by injecting it intramuscularly, rather than intravenously;

m. Inappropriately administers ergotrate agents, such as Methergine, by injecting it transvaginally into the cervix, rather than intramuscularly;

n. Fails to submit the aspirated contents of the uterus to a laboratory for pathological examination;

o. Fails to dispose of the aspirated contents of the uterus and other biohazard materials, such as bloody table sheets, in compliance with CDC guidelines;

p. Fails to maintain the sharps box in accordance with CDC guidelines;

q. Fails to maintain medications in accordance with CDC guidelines;

r. Fails to post CDC guidelines;

s. Fails to maintain policies for sterilization techniques for instruments; and

t. Fails to maintain a clean office, including the consultation room, waiting room, procedure and recovery rooms, and laboratory area.

114. Based on the review by the Board's experts, the facts in regard to Patient A and Patient B that imperatively require emergency action, including but not limited to the following, are that Respondent:

a. Failed to immediately arrange for Patient A's transportation to a hospital where Dilation and Evacuation ("D & E") (abortion) could have been completed, given the power outage and Respondent's inability to complete the D & E in the office in a timely manner and imminent DIC;

b. Continued to perform the D &E during an electrical power outage;

c. Failed to monitor Patient A, including amount of blood loss, during the two hour time frame between the power outage and the second attempt to complete the D & E, or failed to demonstrate that Patient A was adequately monitored despite ongoing bleeding;

d. Failed to respond to Patient A's requests to call her emergency contact;

e. Failed to stop the abortion procedure on Patient B when he suspected a bowel injury, notify paramedics and arrange for

transportation to a hospital by ambulance instead of transporting Patient B in his own automobile, in that Respondent was unable to monitor Patient B or treat any emergent situation which might arise;

f. Failed to exercise sound medical judgment during uncommon. but known, complications of D & E,

g. Performed a myomectomy on Patient B, an elective GYN procedure, while he performed emergency surgery to repair the uterus, possibly leading to further bleeding

VIII. **Disciplinary Grounds**

115. Based on the above investigative facts, the Board has probable cause to believe that Respondent has violated H.O. §§ 14-404(a)(3), (4), (31), and (32). These provisions provide as follows:

(3) Is guilty of immoral or unprofessional conduct in the practice of medicine;

(4) Is professionally, physically, or mentally incompetent;

(31) Except in an emergency life-threatening situation where it is not feasible or practicable, fails to comply with the Centers for Disease control's guideline on universal precautions;

(32) Fails to display the notice required under § 14-415 of this title;

Section 14-415 of the Medical Practice Act states:

If a physician is engaged in the private practice of medicine in the State, the physician shall display the notice developed under § 1-207 of this article conspicuously in each office where the physician is engaged in practice. (H.G. § 1-207 requires the development of a notice written in layman's language that explains the CDC guidelines.)

CONCLUSIONS OF LAW

Based upon the foregoing Investigative Findings, the Board concludes that the public health, safety, or welfare imperatively requires emergency action, and that pursuant to Md. State Govt. Code Ann. § 10-226(c)(2), Respondent's license must be immediately suspended.

ORDER

Based on the foregoing Investigative Findings and Conclusions of Law;

IT IS THIS 1st day of November, 2005, by a majority of a quorum of the Maryland Board of Physicians;

ORDERED that pursuant to the authority vested in the Board by Md. State Govt. Code Ann. § 10-226(c)(2) (2004 Repl. Vol.), the Respondent's license to practice medicine in the State of Maryland be and is hereby **SUMMARILY SUSPENDED;** and be it further

ORDERED that a post-deprivation hearing on the summary suspension in accordance with Code Md. Regs. tit. 10, §32.02.05 B(7) is scheduled on **Wednesday, November 16, 2004 at 2:30 p.m.** at the Maryland Board of Physicians, Room 109, 4201 Patterson Avenue, Baltimore, Maryland, 21215-0095; and be it further

ORDERED that at the conclusion of the **SUMMARY SUSPENSION** hearing before the Board, Respondent, if dissatisfied with the result of the hearing, may request with the (10) days, an evidentiary hearing, such hearing to be held within thirty (30) days of the request, before an administrative Law Judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy road, Hunt Valley, Maryland 21031-1301; and be it further

ORDERED that on presentation of this Order, Respondent **SHALL SURRENDER** to the Board staff the following items:

(1) Respondent's original Maryland license D08238;

(2) Respondent's current renewal certificate;

(3) Respondent's current Federal DEA certificate of Registration # AK3040704, exp. 12/31/07;

(4) Respondent's current Maryland Controlled Substance Registration # M34090, exp. 6/30/06;

(5) All prescribed substances in his possession and/or practice, including all controlled dangerous substances, other than substances, which have been prescribed by a licensed physician for Respondent;

(6) all Medical Assistance prescription forms in his possession and/or practice;

(7) all prescription forms and pads in his possession and/or practice; and

(8) All prescription pads on which his name and DEA number are imprinted; and be it further

ORDERED that a copy of the Order of Suspension shall be filed with the Board immediately in accordance with Md. Health Occ. Code Ann. § 14-407 (2005 Repl. Vol.); and be it further

ORDERED that this is a Final Order of the Board, and as such, is a **PUBLIC DOCUMENT** pursuant to Md. State Govt Code Ann. § 10-611 *et seq.*

10/1/05
Date

C. Irving Pinder, Jr.
Executive Director
Maryland Board of Physicians