Dangerous Maryland Doctors

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Acknowledgments

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Executive Summary

Next week, Maryland doctors will mount a strike and demonstration at the state house, demanding that a new, draconian cap on medical malpractice victims' compensation be enacted. But while doctors do not hesitate to talk about how their insurance premiums are rising, they are more reticent about the individual doctors responsible for half their problem—doctors who have harmed more than one patient.

This report focuses on the very worst repeat offender doctors, who we are calling dangerous doctors.

- It excerpts redacted files of individual doctors contained in the National Practitioner Data Bank (NPDB), maintained by the federal government. Thirty-one doctors, who each made four or more payments to plaintiffs for a total of $41.9 million from 1990 to 2002, cannot be identified due to restrictions on access to the NPDB. This secrecy was ensured by Congress at the urging of doctors' lobbyists. But even with identifying information stricken, the files tell an appalling story of the misery that can be caused by a single negligent doctor. None of these doctors has been disciplined by Maryland authorities.

- The report also lays bare the histories of three individual doctors about whom we have obtained detailed case information, which describe the injuries suffered by the doctors' victims.

We are not publicly disclosing the names of the three doctors. In part, we have withheld their identity to make a point—it should be the responsibility of the Maryland Board of Physicians; of Med-Chi, the Maryland doctors' trade association; and of the federal government through the NPDB to identify these dangerous doctors. But because of opposition from the doctors' lobby at the state and federal levels such information is withheld from the public.

But the impression on the reader will be clear: these records hide the identities of doctors who have harmed numerous patients, and the public ought to be given the right to know this information.

Other findings in the report include:

- **Three percent of doctors are responsible for half the medical malpractice payouts in Maryland.** A small percentage of doctors have attracted multiple claims, and it is these doctors who are responsible for much of the malpractice in Maryland. According to NPDB data, which covers malpractice judgments and settlements since September 1990, just 3 percent of Maryland's doctors have been responsible for 50.8 percent of malpractice payouts to patients. Overall, these 576 doctors, all of whom have made two or more payouts, have paid $317.3 million in damages. Conversely, 89.4 percent of Maryland's doctors have never made a malpractice payout.

- **Doctors with repeated malpractice claims against them suffer few consequences.** The Maryland Board of Physician Quality Assurance, the predecessor for today's Board of Physicians, and the state's health care providers have been criticized in the media and by lawmakers for failing to rein in doctors who repeatedly commit medical errors and medical negligence. According to Public Citizen's analysis of NPDB data, only 20.6 percent (37 of 180) of Maryland doctors who made three or more malpractice payouts since 1990 were disciplined by the Board in any way.

- **The Maryland Board of Physicians has been among the nation's least diligent when it comes to disciplining doctors.** In 2002, Maryland ranked 46th among all states and the District of Columbia for the frequency at which it takes serious disciplinary actions against doctors for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses or other offenses. In 2002, the Board levied serious sanctions against only 39 of its 21,833 doctors. Nationally in 2002, there were 3.6 serious actions taken for every 1,000 physicians. The rate was exactly half that in Maryland – only 1.8 serious actions per 1,000 physicians. Over the past decade, Maryland has descended sharply in its rate of doctor discipline, from its best ranking of 19th in 1993 to its worst ranking of 46th in 2002. In seven of the last 10 years, Maryland has been rated in the bottom half of all states.

- **Under Maryland's new "Physician Profile" law, only five of 180 repeat offender doctors are eligible to have their names made public on the state Web site—and none have yet been posted.** Under the physician discipline reform law enacted last year, the fact that a doctor has settled three or more malpractice cases is supposed to be disclosed, but only if all three occurred during the past five years, and each exceeded $150,000. According to Public Citizen's analysis of National Practitioner Data Bank records, only five doctors are covered by the law. Worse yet, none of the five's records has yet been posted on the Board of Physicians' Web site.

- **Doctor X:** Dr. X is an obstetrician/gynecologist practicing in the Baltimore area. He has made payments to at least seven patients who sued him for medical malpractice since 1981. Payments in four of the seven cases total $1.9 million. In one case, Dr. X punctured a patient's colon during surgery, nearly costing the patient her life. This case resulted in a jury verdict for the patient in June of 2000 of $1.5 million, later reduced due to Maryland's cap on non-economic damages. Dr. X has never been disciplined by the state of Maryland.

- **Doctor Y:** Dr. Y is an orthopedic surgeon practicing in the Baltimore area. He has made payments to at least five patients who sued him for medical malpractice since 1980. In one case, Dr. Y performed an unnecessary carpal tunnel release on a patient that created a cascade of problems. He ordered follow-up procedures to fraudulently conceal his original negligence. As a result, the patient had twelve surgeries in nine years. An arbitrator ruled in favor of the patient and awarded her almost $1.4 million. Doctor Y has never been disciplined by the state of Maryland.

- **Doctor Z:** Dr. Z is an orthopedic surgeon practicing in the Baltimore area. He has made payments to at least six patients who sued him for medical malpractice since 1989. In one case, he lacerated a patient's nerves during carpal tunnel surgery. The case was settled for an undisclosed amount. Doctor Z was put on probation by the state of Maryland within the last 10 years and his probation was terminated two years later. But he currently practices with no restrictions on his license and has three current cases pending against him.

Introduction

Maryland doctors are up in arms about a 28 percent increase in their medical liability insurance premiums by the state's leading insurer – Medical Mutual of Maryland. Doctors deserve some sympathy for having to endure a *temporary* spike in rates due to insurance market economics. But that does not justify turning doctors into medical malpractice "victims" and thereby scapegoating the real victims – an estimated 800 to 1,800 Maryland residents who die each year as a result of preventable medical errors and the countless others who are seriously injured by negligent doctors.

Most of the goods and services offered to American consumers are free from undue hazards. This safety is the result of three systems—choices made by informed consumers; oversight by government regulators; and a legal system that imposes liability for injuries on those who negligently cause harm. Automobiles are far safer today than they were a generation ago because of regulation by the National Highway Traffic Safety Administration, the ready availability of safety information from publications like *Consumer Reports*, and the deterrent effect of litigation over vehicle defects.

Unfortunately, consumers of health care services in Maryland do not benefit from comparable protections. Maryland's Board of Physicians ranks 46th in the nation in the rate of serious disciplinary actions taken against physicians for incompetence, misprescribing drugs, sexual misconduct, criminal convictions and other offenses. A weak statute passed last year requiring public disclosure of doctors' safety records is not being implemented in a meaningful way. Now the state's civil justice system, already hamstrung by a cap on medical malpractice damages, faces further weakening by a proposal to dramatically lower the cap. Doctors have lobbied hard against measures to protect patients by any of these three means.

The result is that there is no effective means for removing dangerous doctors from practice in Maryland. There are a small number of such doctors in Maryland, and they have been responsible for a disproportionately large number of malpractice payouts to injured patients and largely gone undisciplined. Their names have been hidden from public view. And they have thrived under Maryland's cap on so-called "non-economic damages," which has shifted the costs of their negligence onto injured patients.

Ninety percent of Maryland doctors have never lost or settled a malpractice lawsuit. But as this report makes clear, the damage wrought by a minority of undisciplined repeat-offender doctors is substantial. The complete record of the harm they caused cannot be seen. Those records lie hidden in the National Practitioner Data Bank (NPDB), a federal agency whose information, as a result of intense lobbying by doctors, is kept secret from the public. What can be provided is only a partial reconstruction but one that is nevertheless compelling.

This report highlights some of Maryland's most dangerous doctors. The stories of three of the doctors, and their victims, are told in detail. We began our research using two different sources: redacted files of the National Practitioner Data Bank, which assign only a random number to

each doctor; and Maryland attorneys who have encountered repeat offender doctors while representing injured patients.

We are not publicly disclosing the names of the doctors. We have withheld the identity of these doctors in part to make a point – it should be the responsibility of the Maryland Board of Physicians; of Med-Chi, the Maryland doctors' trade association; and of the federal government through the NPDB to identify these dangerous doctors. But because of opposition from the doctors' lobby at the state and federal levels such information is withheld from the public.

But the impression on the reader will be clear: these records hide the identities of doctors who have harmed numerous patients, and the public ought to be given the right to know this information.

For each doctor, the three critical safety systems have failed. None of the doctors' licenses have been revoked. None of the doctors' public profiles, posted on the state Board of Physician's Web site, reveal the damage that the doctors have inflicted. Finally, state legislation passed in 1986 that limited doctors' liability for malpractice facilitated each doctor's ability to obtain liability insurance and they remain in practice despite posing an unacceptable to risk to the public.

Section I

Overview of Dangerous Maryland Doctors and How to Reduce Their Number

Three Percent of Doctors Are Responsible for Half the Medical Malpractice Payouts in Maryland

The insurance and medical communities argue that medical malpractice litigation constitutes a giant "lottery," in which lawsuits are purely random events bearing no relationship to the care given by a physician. If the tort system is a lottery, it is clearly a rigged one, because some numbers come up more often than others. A small percentage of doctors have attracted multiple claims and malpractice payouts, and it is these doctors who are responsible for most of the malpractice payouts to victims in Maryland.

- According to the federal government's National Practitioner Data Bank (NPDB), which is the most comprehensive repository of information on doctors' malpractice and disciplinary records, since September 1990 just 3 percent of Maryland's doctors have been responsible for 50.8 percent of malpractice payouts (judgments and settlements) to patients. [See Figure 1] Overall, these 576 doctors, all of whom have made two or more payouts, paid $317.3 million in damages from 1990 through 2002.

- Even more surprising, just 0.9 percent of Maryland doctors (180), each of whom has paid three or more malpractice claims, were responsible for 24.1 percent of all payouts.

- 89.4 percent of Maryland doctors have never made a malpractice payout.

Figure 1

Number of Medical Malpractice Payouts to Patients and Amounts Paid by Maryland Doctors, 1990-2002

Number of Payout Reports	Number of Doctors That Made Payouts	Percent of Total Doctors (19,215)*	Total Number of Payouts	Total Amount of Payouts	Percent of Total Number of Payouts
All	2,037	10.6%	2,967	$653,453,300	100.0%
1	1,461	7.6%	1,461	$336,185,800	49.2%
2 or More	576	3.0%	1,506	$317,267,500	50.8%
3 or More	180	0.9%	714	$137,701,550	24.1%
4 or More	67	0.3%	375	$68,134,500	12.6%
5 or More	33	0.2%	239	$39,551,000	8.1%

Source: National Practitioner Data Bank, Sept. 1, 1990 – Dec. 31, 2002.
**Note:* Based on Maryland's population of doctors as calculated by the American Medical Association for 1995, the closest year for which such data is available to the mid-point of the period studied.

Doctors with Repeated Malpractice Judgments and Settlements Against Them Suffer Few Consequences

The Maryland Board of Physicians and the state's health care providers have been criticized in the media and by lawmakers for failing to rein in doctors who repeatedly commit medical errors and medical negligence.[1] This criticism is confirmed by an analysis of National Practitioner Data Bank data, showing that Maryland doctors can make up to 10 malpractice payouts without facing more than a 50 percent chance that *any* disciplinary action, much less a license suspension or revocation, or a limit on clinical privileges, will be taken against them. [See Figure 2] Among other findings:

- 14.1 percent (81 of 576) of Maryland doctors who made two or more malpractice payouts were disciplined by the Board of Physicians.
- 20.6 percent (37 of 180) of Maryland doctors who made three or more malpractice payouts were disciplined by the Board of Physicians.
- 34.3 percent (23 of 67) of Maryland doctors who made four or more malpractice payouts were disciplined by the Board of Physicians.
- 42.4 percent (14 of 33) of Maryland doctors who made five or more malpractice payouts were disciplined by the Board of Physicians.

Figure 2

Maryland Doctors with Two or More Malpractice Payouts Who Have Been Disciplined (Reportable Licensure Actions) 1990-2002

Number of Payout Reports	Number of Doctors Who Made Payouts	Number of Doctors with Two or More Licensure Actions	Percentage of Doctors with Two or More Licensure Actions
2 or More	576	81	14.1%
3 or More	180	37	20.6%
4 or More	67	23	34.3%
5 or More	33	14	42.4%
10 or More	6	3	50.0%

Source: National Practitioner Data Bank, Sept. 1, 1990 – Dec. 31, 2002.

Dangerous Maryland Doctors Who Have Never Been Disciplined

Unfortunately, National Practitioner Data Bank files identifying doctors by name are kept secret from the public. However, NPDB releases a "public use" file that shows individual doctors' records but it is redacted of any identifying information other than the states in which they are practicing.

As noted in Figures 1 and 2, since 1990 there have been 180 doctors in Maryland who have made three or more medical malpractice payouts. Of these 180, 143 have never been disciplined in any way by the Board of Physicians. On the following pages are profiles of 31 of these 143 undisciplined doctors, who each had four or more judgments or settlements against them. They paid out a total of $41.9 million from 1990 through 2002. Of these doctors who still practice, all of them remain eligible to see patients in Maryland. But their patients have no way of knowing the doctor's complete malpractice history.

Figure 3

Maryland Doctors with Four or More Judgments and/or Settlements Who Have Never Been Disciplined

Dr. ID No.	Payout Year	Year of Incident	Payout Range (+ -)*	Malpractice Act	Pay Type Described	Work State
15955	1990	1985	$125,000	Surgery – Improper management of surgery	Settlement	MD
15955	1995	1993	$97,500	Treatment – Improper performance of treatment / procedure	Unknown	DC
15955	1996	1991	$795,000	Surgery (not otherwise coded)	Unknown	DC
15955	1998	1995	$445,000	Treatment – Failure to treat	Settlement	DC
15955	1998	1998	$77,500	Surgery (not otherwise coded)	Settlement	DC
15955	1999	1999	$42,500	Surgery – Improper management of surgery	Settlement	DC
15955	2000	1995	$145,000	Surgery – Unnecessary surgery	Settlement	DC
15955	2002	1997	$2,150,000	Surgery – Improper positioning	Settlement	MD
15955	2002	1999	$595,000	Diagnosis – Delay in diagnosis	Settlement	MD
Total			**$4,472,500**			
7256	1993	1989	$315,000	Surgery – Improper performance of surgery	Unknown	MD
7256	1996	1991	$495,000	Obstetrics -- Failure to identify/treat fetal distress	Settlement	MD
7256	2000	1996	$995,000	Obstetrics -- Improperly managed labor	Settlement	MD
7256	2001	1996	$1,750,000	Obstetrics -- Failure to manage pregnancy	Settlement	MD
Total			**$3,555,000**			

Dr. ID No.	Payout Year	Year of Incident	Payout Range (+ -)*	Malpractice Act	Pay Type Described	Work State
15738	1992	1987	$845,000	Obstetrics -- Improperly managed labor	Settlement	MD
15738	1994	1987	$87,500	Surgery (not otherwise coded)	Settlement	MD
15738	1996	1995	$495,000	Obstetrics (not otherwise coded)	Settlement	MD
15738	1998	1991	$295,000	Diagnosis -- Delay in diagnosis	Unknown	MD
15738	1999	1983	$195,000	Obstetrics -- Improperly performed vaginal surgery	Settlement	MD
15738	2001	1995	$625,000	Diagnosis -- Delay in diagnosis	Settlement	MD
Total			**$2,542,500**			

15662	1991	1985	$12,500	Surgery -- Improper management of surgery	Settlement	MD
15662	1992	1985	$345,000	Surgery -- Unnecessary surgery	Settlement	MD
15662	1998	1995	$37,500	Surgery (not otherwise coded)	Settlement	MD
15662	2000	1987	$1,050,000	Surgery -- Improper management of surgery	Judgment	MD
15662	2000	1987	$1,050,000	Surgery -- Unnecessary surgery	Settlement	MD
Total			**$2,495,000**			

16327	1990	1988	$145,000	Obstetrics -- Failure to identify/treat fetal distress	Settlement	MD
16327	1991	1985	$17,500	Treatment -- Improper performance of treatment / procedure	Settlement	MD
16327	1994	1992	$195,000	Obstetrics -- Improper choice of delivery method	Settlement	MD
16327	1996	1992	$295,000	Obstetrics -- Delay in treatment of identified fetal distress	Settlement	MD
16327	1997	1993	$945,000	Obstetrics (not otherwise coded)	Settlement	MD
16327	2000	1998	$895,000	Surgery -- Improper performance of surgery	Settlement	MD
Total			**$2,492,500**			

15701	1993	1989	$995,000	Obstetrics -- Delay in treatment of identified fetal distress	Settlement	MD
15701	1998	1992	$27,500	Surgery -- Retained foreign body	Settlement	MD
15701	2001	1997	$825,000	Obstetrics (not otherwise coded)	Settlement	MD
15701	2001	1996	$645,000	Obstetrics (not otherwise coded)	Settlement	MD
Total			**$2,492,500**			

15669	1991	1988	$995,000	Diagnosis -- Failure to diagnose	Settlement	MD
15669	1993	1989	$995,000	Treatment -- Improper management of a course of treatment	Settlement	MD
15669	1995	1990	$195,000	Obstetrics -- Improperly performed vaginal surgery	Settlement	MD
15669	1997	1992	$6,250	Obstetrics -- Failure to manage pregnancy	Unknown	MD
Total			**$2,191,250**			

15675	1991	1986	$97,500	Obstetrics -- Failure to manage pregnancy	Settlement	MD
15675	1991	1987	$195,000	Diagnosis -- Failure to diagnose	Settlement	MD
15675	1998	1988	$995,000	Obstetrics (not otherwise coded)	Settlement	MD

Dr. ID No.	Payout Year	Year of Incident	Payout Range (+ -)*	Malpractice Act	Pay Type Described	Work State
15675	1999	1997	$795,000	Obstetrics -- Failure to manage pregnancy	Settlement	MD
Total			**$2,082,500**			
92701	1996	1991	$495,000	Obstetrics (not otherwise coded)	Settlement	MD
92701	1997	1986	$995,000	Obstetrics (not otherwise coded)	Settlement	
92701	1997	1992	$145,000	Obstetrics (not otherwise coded)	Settlement	MD
92701	1998	1986	$295,000	Obstetrics (not otherwise coded)	Unknown	MD
Total			**$1,930,000**			
16112	1992	1989	$875,000	Diagnosis -- Delay in diagnosis	Settlement	MD
16112	1994	1991	$495,000	Diagnosis -- Delay in diagnosis	Settlement	MD
16112	2000	1997	$195,000	Diagnosis -- Delay in diagnosis	Settlement	MD
16112	2002	1997	$17,500	Medication -- Failure to medicate	Settlement	MD
Total			**$1,582,500**			
16023	1990	1987	$52,500	Obstetrics (not otherwise coded)	Settlement	MD
16023	1997	1985	$775,000	Obstetrics (not otherwise coded)	Settlement	MD
16023	2000	1986	$395,000	Obstetrics (not otherwise coded)	Settlement	MD
16023	2001	1996	$245,000	Treatment (not otherwise coded)	Settlement	MD
Total			**$1,467,500**			
15711	1993	1988	$635,000	Surgery (not otherwise coded)	Settlement	MD
15711	1994	1990	$8,750	Surgery (not otherwise coded)	Settlement	MD
15711	1995	1989	$495,000	Treatment (not otherwise coded)	Settlement	MD
15711	1995	1990	$245,000	Treatment (not otherwise coded)	Settlement	MD
15711	2001	1993	$47,500	Surgery (not otherwise coded)	Settlement	MD
Total			**$1,431,250**			
69563	1995	1989	$97,500	Surgery -- Improper performance of surgery	Settlement	MD
69563	1999	1995	$595,000	Surgery (not otherwise coded)	Settlement	MD
69563	2000	1994	$285,000	Surgery -- Improper performance of surgery	Settlement	MD
69563	2001	1998	$195,000	Surgery -- Improper performance of surgery	Settlement	MD
69563	2002	1995	$245,000	Medication (improper management of medication regimen)	Unknown	MD
Total			**$1,417,500**			
15893	1992	1989	$37,500	Wrongful life/birth	Settlement	MD
15893	1994	1990	$995,000	Obstetrics (not otherwise coded)	Settlement	MD
15893	1998	1996	$295,000	Obstetrics -- Improper choice of delivery method	Settlement	MD
15893	2000	1994	$87,500	Obstetrics -- Failure to identify/treat fetal distress	Settlement	MD
Total			**$1,415,000**			
7207	1991	1983	$595,000	Diagnosis -- Wrong diagnosis	Judgment	DC
7207	1997	1994	$325,000	Diagnosis -- Failure to diagnose	Settlement	MD
7207	1998	1993	$195,000	Diagnosis -- Failure to diagnose	Settlement	MD
7207	1999	1994	$145,000	Diagnosis -- Failure to diagnose	Settlement	MD
Total			**$1,260,000**			

Dr. ID No.	Payout Year	Year of Incident	Payout Range (+ -)*	Malpractice Act	Pay Type Described	Work State
15676	1991	1988	$42,500	Obstetrics (not otherwise coded)	Settlement	MD
15676	1994	1988	$82,500	Obstetrics (not otherwise coded)	Settlement	MD
15676	1995	1987	$6,250	Obstetrics (not otherwise coded)	Settlement	MD
15676	1997	1994	$47,500	Diagnosis -- Failure to diagnose	Settlement	MD
15676	1997	1994	$665,000	Treatment -- Improper management of a course of treatment	Settlement	MD
15676	1999	1989	$225,000	Obstetrics -- Failure to manage pregnancy	Unknown	MD
15676	2000	1998	$17,500	Obstetrics -- Improperly managed labor	Settlement	MD
Total			**$1,086,250**			
25714	1993	1986	$385,000	Diagnosis -- Failure to diagnose	Settlement	MD
25714	1993	1986	$225,000	Diagnosis -- Failure to diagnose	Settlement	MD
25714	1993	1986	$185,000	Diagnosis -- Failure to diagnose	Settlement	MD
25714	2002	1998	$225,000	Diagnosis (not otherwise coded)	Settlement	MD
			$1,020,000			
93969	1996	1988	$525,000	Obstetrics (not otherwise coded)	Judgment	MD
93969	1998	1990	$77,500	Surgery (not otherwise coded)	Unknown	MD
93969	1998	1996	$345,000	Obstetrics (not otherwise coded)	Settlement	MD
93969	2001	1992	$77,500	Obstetrics -- Failure to identify/treat fetal distress	Settlement	MD
Total			**$1,025,000**			
15799	1991	1986	$125,000	Diagnosis -- Delay in diagnosis	Settlement	MD
15799	1994	1991	$105,000	Wrongful life/birth	Unknown	MD
15799	1994	1991	$72,500	Wrongful life/birth	Unknown	MD
15799	2001	1998	$645,000	Obstetrics (not otherwise coded)	Settlement	MD
Total			**$947,500**			
133824	1999	1995	$495,000	Obstetrics -- Improper choice of delivery method	Settlement	MD
133824	2000	1994	$87,500	Obstetrics -- Failure to manage pregnancy	Settlement	MD
133824	2001	1997	$145,000	Diagnosis -- Failure to diagnose	Settlement	MD
133824	2001	1997	$22,500	Diagnosis -- Failure to diagnose	Settlement	MD
Total			**$750,000**			
15963	1991	1985	$105,000	Diagnosis -- Failure to diagnose	Settlement	MD
15963	1991	1985	$47,500	Diagnosis -- Failure to diagnose	Unknown	MD
15963	1997	1995	$77,500	Surgery (not otherwise coded)	Settlement	MD
15963	1998	1994	$225,000	Treatment -- Improper management of a course of treatment	Settlement	MD
15963	2002	1998	$165,000	Surgery -- Improper performance of surgery	Settlement	MD
Total			**$620,000**			
16331	1992	1988	$345,000	Medication administration related	Settlement	MD
16331	1997	1994	$37,500	Surgery -- Wrong body part	Before Settlement	MD
16331	1997	1992	$97,500	Diagnosis -- Failure to diagnose	Settlement	MD
16331	1999	1994	$37,500	Treatment (not otherwise coded)	Settlement	MD

Dr. ID No.	Payout Year	Year of Incident	Payout Range (+ -)*	Malpractice Act	Pay Type Described	Work State
16331	2002	1996	$57,500	Obstetrics (not otherwise coded)	Judgment	MD
Total			**$575,000**			
68773	1995	1970	$97,500	Obstetrics (not otherwise coded)	Settlement	MD
68773	1999	1995	$72,500	Obstetrics (not otherwise coded)	Unknown	MD
68773	2000	1998	$125,000	Obstetrics (not otherwise coded)	Settlement	MD
68773	2000	1998	$97,500	Obstetrics (not otherwise coded)	Settlement	MD
68773	2000	1998	$82,500	Treatment (not otherwise coded)	Settlement	MD
68773	2002	1997	$72,500	Surgery (not otherwise coded)	Settlement	MD
Total			**$547,500**			
16064	1993	1990	$72,500	Surgery (not otherwise coded)	Settlement	MD
16064	1997	1991	$245,000	Diagnosis -- Delay in diagnosis	Settlement	MD
16064	1998	1993	$82,500	Surgery -- Improper performance of surgery	Settlement	MD
16064	1998	1993	$82,500	Surgery (not otherwise coded)	Settlement	MD
16064	2002	1997	$62,500	Diagnosis -- Failure to diagnose	Settlement	DC
Total			**$545,000**			
54745	1994	1988	$195,000	Surgery (not otherwise coded)	Settlement	MD
54745	1996	1990	$97,500	Surgery (not otherwise coded)	Settlement	MD
54745	1999	1989	$12,500	Surgery (not otherwise coded)	Settlement	MD
54745	2001	1995	$115,000	Diagnosis -- Wrong diagnosis	Judgment	MD
Total			**$420,000**			
15957	1990	1988	$52,500	Surgery (not otherwise coded)	Settlement	MD
15957	1992	1987	$17,500	Surgery - retained foreign body	Settlement	MD
15957	1994	1991	$22,500	Surgery -- Improper positioning	Settlement	MD
15957	2001	1994	$265,000	Treatment -- Failure to treat	Settlement	MD
Total			**$357,500**			
61776	1994	1992	$22,500	Surgery -- Retained foreign body	Settlement	MD
61776	1995	1993	$8,750	Treatment (not otherwise coded)	Settlement	MD
61776	1997	1991	$205,000	Obstetrics -- Delay in treatment of identified fetal distress	Settlement	NC
61776	2000	1995	$97,500	Obstetrics -- Improperly performed vaginal surgery	Settlement	MD
Total			**$333,750**			
16100	1994	1989	$175,000	Treatment -- Failure to obtain consent / Lack of informed consent	Judgment	MD
16100	1997	1990	$62,500	Treatment (not otherwise coded)	Settlement	MD
16100	1997	1996	$1,500	Treatment (not otherwise coded)	Before settlement	MD
16100	1999	1995	$1,500	Treatment (not otherwise coded)	Settlement	MD
Total			**$240,500**			
16049	1992	1987	$8,750	Diagnosis -- Failure to diagnose	Settlement	MD
16049	1994	1991	$8,750	Surgery -- Improper performance of surgery	Judgment	MD
16049	1997	1991	$135,000	Obstetrics -- Wrongful life/birth	Settlement	MD
16049	1998	1994	$72,500	Surgery (not otherwise coded)	Settlement	MD
Total			**$225,000**			

Dr. ID No.	Payout Year	Year of Incident	Payout Range (+ -)*	Malpractice Act	Pay Type Described	Work State
15696	1993	1988	$47,500	Surgery -- Improper performance of surgery	Settlement	MD
15696	1994	1988	$22,500	Treatment -- Wrong treatment / procedure performed	Settlement	MD
15696	1996	1994	$1,500	Treatment -- Improper performance of treatment/procedure	Settlement	MD
15696	1998	1994	$145,000	Surgery -- Improper performance of surgery	Settlement	MD
Total			**$216,500**			
16167	1992	1987	$32,500	Surgery (not otherwise coded)	Settlement	MD
16167	1995	1992	$32,500	Surgery -- Wrong body part	Settlement	MD
16167	1998	1996	$97,500	Diagnosis -- Failure to diagnose	Settlement	MD
16167	2002	2001	$32,500	Diagnosis (not otherwise coded)	Settlement	MD
Total			**$195,000**			
All Doctors Total			**$41,932,000**			

Source: National Practitioner Data Bank, Sept. 1, 1990 – Dec. 31, 2002.
*Payout amounts are not exact but are rounded according to an NPDB formula.

Maryland's Poor Record of Disciplining Bad Doctors

Automobile insurers lobby state legislators for strict laws suspending or revoking the licenses of dangerous drivers, in order to keep insurance rates lower for safe drivers. Unfortunately, doctors' insurers deviate from this sensible policy position, perhaps because most companies are owned by doctors themselves. If efforts were made to redirect repeat offender doctors into less risky practice areas, or out of practice altogether, the savings in insurance premiums could far exceed any savings that might come from damage caps. More importantly, patients would be reassured that their medical care would be safer.

Opportunities for Maryland to cut its rate of malpractice claims by reducing the frequency of medical errors and negligence have been undercut by the Maryland Board of Physicians' failure to diligently discipline doctors who commit repeated malpractice.

The Board of Physicians has been among the nation's least diligent when it comes to disciplining doctors. In 2002, Maryland ranked 46th among all states and the District of Columbia for the frequency at which it takes serious disciplinary actions against doctors for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses or other offenses. In 2002, the Board levied serious sanctions against only 39 of its 21,833 doctors, according to Public Citizen's Health Research Group ranking of the rate of state medical boards' serious disciplinary actions in 2002.[2]

Nationally in 2002, there were 3.6 serious actions taken for every 1,000 physicians. The rate of serious actions by the Maryland board were half that – 1.8 per 1,000 physicians – and was roughly one-sixth of the rate in Wyoming, which is the top-ranked state with 11.9 serious actions per 1,000 physicians.[3]

Over the past decade, Maryland has descended sharply in its rate of doctor discipline, from its best ranking of 19th in 1993 to its worst ranking of 46th in 2002. In seven of the last 10 years, Maryland has been rated in the bottom half of all states.[4]

A 2000 study by the state's Office of Legislative Audits found that the Board of Physicians failed to take action on 140 of 493 complaints against doctors within four years of receiving those complaints.[5] This was among the shortcomings that prompted lawmakers to seek improvements in the physician discipline process – an effort that failed in 2002 after heavy lobbying by Med-Chi. This led one frustrated legislator to complain to the media that the Board "is very geared toward doing nothing."[6]

In 2003, the Maryland General Assembly finally acted to re-vamp the medical board.[7] Board membership was increased from 15 to 21 and the statute increased the number of consumer members from 2 to 5, or 24 percent of the total. It remains to be seen whether the token increase in consumer representation on the board will lead to more effective disciplinary actions.

Responsibility for conducting investigations of physician complaints was taken from MedChi and placed in the hands of an outside contractor, who it turns out, will be the Delmarva Foundation. This is a hopeful sign. Since 1986 Delmarva has served as the Maryland Medicare Quality Improvement Organization and since 1997 Delmarva has served as the Maryland External Quality Review Organization.

The chief lobbyist for Med-Chi, however, received public credit from the doctors' group for fighting off several reforms that would have made the disciplinary process much more stringent.[8]

For example, despite the recommendation of the Federation of State Medical Boards (FSMB), the General Assembly retained "clear and convincing" evidence as the standard of proof required in matters involving quality of medical and surgical care. The FSMB's special committee had found that the standard of proof required of boards in disciplinary proceedings can have a substantial impact on overall board disciplinary activity and effectiveness. The Committee recommended a uniform standard of "preponderance of the evidence" as higher standards of proof, like "clear and convincing" evidence, make taking a disciplinary action against an errant physician more difficult. This is a critical failure of the new statute.[9]

After opposition from Med-Chi, the physician profiles to be made publicly available on the Internet were only required to include the **number** of malpractice final judgments against the licensee in the last 10 years and also the **number** of malpractice settlements if there are three or more with each being at least $150,000 within the last 5 years. It is doubtful whether simply including the number of lawsuits against a physician will provide the consumer with the information necessary to make an informed decision in selecting his or her doctor. Even so, although the statute became effective July 1, 2003, the profiles are still largely incomplete.

Currently it is impossible to determine whether these changes will improve patient safety in Maryland. To date Public Citizen's efforts to obtain a copy of the report required by the new law for State governmental offices by January 1, 2004, on the investigative caseloads and recommendations for improved investigation processes have not been successful.

Improve Maryland's Physician Profile System that Provides Public Information About Dangerous Doctors

The new Maryland patient safety law passed in 2003 ordered the Board of Physicians to create profiles of doctors, containing the kind of information the public needs to avoid the dangerous ones, and place them online. Public Citizen has monitored implementation of the law and found that its reach is so narrow that only five of the 180 three-time repeat offender doctors in Maryland actually meet the criteria to be identified. Worse still, although the Board could learn the identity of those doctors by making one phone call, they have not yet identified a single one of the five on their Web site.

The entire health care establishment—from insurers and providers to the employers who pay for the system—insist that all that is needed to assure health care quality are "report cards." But in Maryland, the critical information on quality and safety is taking years to be made public, and most will still be kept secret.

Comparing New York State's disclosure statute, on which the initial Maryland proposal was based, to the Maryland law shows how a well-intentioned law can be significantly weakened. Guilty verdicts and arbitration awards are supposed to be disclosed, but only if "all appeals have been exhausted." Public Citizen's spot check indicates that some payments we know to have been made to plaintiffs after jury verdicts or arbitration awards have been reported to NPDB as "settlements," presumably because the doctor waived a right to appeal in exchange for an immediate payment. Since there is nearly always some avenue for appeal relinquished even after a verdict or arbitration award, the provision may prove to be a nullity.

Malpractice settlements that are made by doctors, even ones made after their trials have started to go badly, are kept out of the state profile system unless a doctor accumulates at least three settlements of over $150,000 each over five years. Our search of the NPDB's public use dataset found only five doctors who paid at least three settlements exceeding $150,000 each in the past five years—about 2 percent of the 180 doctors who have settled three or more cases over the past thirteen years.

In beginning implementation of the law, the new Board has decided to rely on self-reporting by doctors at the time of their biennial license renewal. In 2003, the year the law was passed, only physicians with last names beginning with M-Z renewed. Those with A-L surnames have not yet. The Board has informed Public Citizen that not a single doctor has had his or her malpractice record included in a profile thus far, and the Board has not utilized information from the National Practitioner Data Bank to proactively implement disclosure.[10]

In short, the disclosure provisions may be as ineffective as the new federal law prohibiting "spam" e-mails. Med-Chi lobbyists may have induced the legislature to enact a law that could prove to be little more than a fraud on Maryland consumers.

Section II

Three of Maryland's Dangerous Doctors

Introduction

This section details the professional careers of three of Maryland's dangerous doctors. Each of them has been sued multiple times for medical malpractice, often resulting in compensation for the victims. All three are still licensed to practice and have medical privileges at hospitals in the state of Maryland.

This section is divided into three subsections, one for each doctor. Each subsection begins with an overview of the doctor's medical, legal and disciplinary history. The overview is followed by summaries of several cases that illustrate the substandard level of care that the doctors have provided to their patients.

In profiling these doctors, many sources were used including court records, the victims and their attorneys, and reports by medical experts or their depositions. Unfortunately, we are unable to report the specific damages obtained in each case. The parties to a court settlement may agree that the terms and conditions of their settlement will remain confidential. Usually, it is the defendants in medical malpractice cases that demand the settlement be confidential and insist on the plaintiff's promise to keep it confidential as a condition of the settlement. As a result, court records simply show that a malpractice lawsuit has been dismissed with prejudice, but provide no information as to the amount of damages paid by the defendant to obtain the plaintiff's agreement to settle.

The profiled doctors are:

Dr. X. Dr. X is an obstetrician/gynecologist practicing in the Baltimore area. He has made payments to at least seven patients who sued him for medical malpractice since 1981. He has never been disciplined by the state of Maryland.

Dr. Y. Dr. Y is an orthopedic surgeon practicing in the Baltimore area. He has made payments to at least five patients who sued him for medical malpractice since 1980. He has never been disciplined by the state of Maryland.

Dr. Z. Dr. Z is an orthopedic surgeon practicing in the Baltimore area. He has made payments to at least six patients who sued him for medical malpractice since 1989. He was put on probation by the state of Maryland within the past ten years and his probation was terminated two years later. But he currently practices with no restrictions on his license and has numerous current cases pending against him.

Doctor X

Dr. X is an obstetrician/gynecologist practicing in Baltimore, Maryland. He has paid out at least $1.9 million to four of the seven patients we know he has made payments to (three payments were for undisclosed amounts). Judgments against Dr. X and cases that have resulted in settlements have included the following:

- Baby Boy Andrew[11] is a case filed in 1989 where Dr. X failed to recognize abnormal non-stress tests resulting in the death of an infant. It was settled for $150,000 in 1990.
- Baby Boy Brandon is a case filed in 1992 where Dr. X vaginally delivered a baby despite the mother's herpes infection, resulting in the death of the baby. It was settled out of court for $200,000 in 1994.
- Baby Girl Chloe is a case filed in 1993 where Dr. X's failure to recognize and respond to signs of fetal distress resulted in irreversible brain damage to an infant. It was settled out of court for $600,000.
- Baby Girl Danielle is a case filed in 1994 where Dr. X failed to recognize a pregnant patient's strep infection, resulting in irreversible brain damage to her baby. It was settled for an undisclosed amount.
- Emily is a case filed in 1998 where Dr. X punctured a patient's colon during surgery, nearly costing the patient her life. It resulted in a jury verdict for the patient in June of 2000 with damages of about $926,000 (originally $1.5 million, but reduced due to Maryland's non-economic damages cap).
- Hannah is a case filed in 2000 where a patient died after suffering a pulmonary embolism following a high risk delivery by Dr. X. It was settled for an undisclosed amount in 2001.
- Grace is a case filed in 2001 where Dr. X failed to respond to mammography reports indicating a mass in a patient's breast that later developed cancer. It was resolved for an undisclosed amount.

Despite the numerous lawsuits filed against him throughout his career, Dr. X has never been disciplined by the state of Maryland. His license to practice is unrestricted. He still has hospital privileges. He can still get insurance to practice medicine. A Baltimore attorney who represented Baby Boy Brandon's family in a 1992 lawsuit against Dr. X wrote letters to the Maryland Board of Physician Quality Assurance (now the Board of Physicians) in 1994 and 2000 calling for an investigation of Dr. X's competency. The 1994 complaint prompted a review of Dr. X by the Board, but the review ended with no formal action being taken. Another review is underway prompted by the second complaint filed by the attorney, but the status of that review is unclear and Dr. X continues to see patients.

Baby Boy Brandon

Facts: An 18 year-old young woman was seeing Dr. X for prenatal care in connection with her first pregnancy. She saw Dr. X approximately ten days before her expected delivery date. She was advised by Dr. X that she was fine and a normal delivery could be expected. She went to the hospital in labor on May 22, 1992. A first-year resident, examined her prior to delivery and noted that she had lesions on her labia so he ordered herpes cultures. Unfortunately, a herpes culture takes 48 hours so there were no results immediately available.

The resident advised his senior resident and Dr. X of the apparent herpes lesion. The senior resident also believed it to be a herpes lesion, and so advised Dr. X. Dr. X examined her, saw the lesion and asked her if she had herpes and upon a negative reply decided to ignore the lesion. He then proceeded with a vaginal delivery of the baby.

In an instance where the mother does have herpes, standard medical procedure would be for a Cesarean section to be performed to prevent infecting the baby. Shortly after Baby Boy Brandon's birth, he developed respiratory distress, hypothermia and poor circulation. He was diagnosed with a herpes infection and died as a result of it on June 10, just 18 days after his birth. The 18 days were agony for both the first-time parents and the infant. The medical records indicate that he was not fed at the end of his short life in order to end his suffering.

This was the first "outbreak" of herpes for this young woman and the risk of infecting the child by vaginal delivery was, therefore, at its greatest. She did not know that she had herpes and had never been treated for it. Dr. X had an absolute obligation to deliver the child by Cesarean, but he took a chance. Dr. X called the distraught mother after the funeral and said "things happen." He then falsified his medical records to say that during the conversation she had "admitted to knowing she had herpes but had lied to him" – a falsehood created by Dr. X.

Outcome: Case dismissed with prejudice and settled for $200,000.

Baby Girl Chloe

Facts: On April 17, 1992, Baby Girl Chloe's mother arrived at the hospital's labor and delivery suite in labor. Upon admission, her obstetrician, Dr. X, ordered use of the drug Pitocin to strengthen her contractions. She was attached to a fetal monitoring machine, which printed out the fetal heart rate and contractions on a continuing basis. The purpose of the machine is to continuously monitor the well being of the unborn baby. Dr. X saw the young woman around 8:00 a.m. and ruptured her membranes, which revealed clear amniotic fluid. Once the membranes have been ruptured, the standard of care requires that delivery must occur within a reasonable time. Dr. X began trying to achieve a vaginal delivery. At 9:30 and 11:15, in the absence of progress, he ordered that the Pitocin be increased. However, the mother did not progress toward a vaginal delivery. At 1:30 p.m., the mother was still in labor, attached to the monitor and being infused with Pitocin. Clear signs of fetal distress were beginning to show. The fetal monitoring strip began to reveal decelerations (slowing of the baby's heart rate) and late decelerations during the ongoing contractions. A Cesarean section should have been performed at this time to end the distress that the baby was experiencing. Dr. X finally arrived at 2:20 p.m., nevertheless he failed to order a Cesarean section to remove the baby from what had become a hostile environment. The baby continued to be in distress.

At 4:15 p.m., the Pitocin was increased again, adding to the fetal distress already being experienced. Baby Girl Chloe was clearly suffering from oxygen deprivation. She was finally born vaginally at 5:25 pm. She was a blue baby with no reflexes, no spontaneous respiration and no muscle tone. Despite standard procedure, there was no pediatrician present at her birth to address the brain injuries she suffered as a result of her traumatic delivery. She suffered further deprivation of oxygen and brain damage while waiting for the pediatricians to arrive. An appropriate immediate resuscitation was not completed by the pediatric staff. When finally transferred to the Newborn Intensive Care Unit at 5:45 p.m., the staff there noted that she was cold, had no heart rate, no respiration and required emergency intubation and resuscitation to save her life.

This baby girl suffered massive and irreversible brain injury. She will never enjoy a normal childhood, adolescence or adulthood, will not attend normal schools, and will not engage in activities in which normal children or adults engage. She will never marry, never enjoy her own children, and will require ongoing care for even her most basic of needs for the rest of her life.

Outcome: Settled for $600,000.

Baby Girl Danielle

Facts: In the fall of 1992, Baby Girl Danielle's mother went to Dr. X for prenatal care and treatment involved with the pregnancy of her first child. Her due date was May 28, 1993. She was told that her pregnancy appeared normal and uncomplicated. Her prenatal care continued in a normal and uncomplicated fashion until April 19, 1993, when she, then 35 weeks along, went to Dr. X complaining about pressure on her bladder. Dr. X performed an internal examination and discovered that she was three to four centimeters dilated. Preterm dilatation under these circumstances often indicates the presence of a Group B Strep infection which requires immediate treatment. Dr. X neither admitted her to the hospital nor performed any further tests at that time; these were violations of the normal standard of care. As a result, a bacterial infection went undiagnosed and untreated.

The next day, at 7:00 a.m., the young woman was again examined by Dr. X who determined that she was now six centimeters dilated and was experiencing mild contractions. She was admitted right away and at 7:45 a.m., labor was induced through the use of the drug Pitocin, which strengthens contractions. Dr. X ruptured her membranes at 8:00 a.m. The untreated infection, the use of Pitocin and the use of other central nervous system depressants, including Demoral and Phenergan, led to a decreased heartbeat in the unborn baby as shown by the repeated decelerations on the attached monitoring strip. Rather than perform a Cesarean section to reduce the stress level of the baby, Dr. X tried to achieve a vaginal delivery.

Baby Girl Danielle was born vaginally at 11:30 a.m. in a depressed state. She was born with asphyxia and a severe and irreversible brain injury due to the effects of the untreated infection as well as the hostile labor. At this point, cultures were finally taken, which confirmed that her mother had a Strep infection that left Baby Girl Danielle suffering from septicemia (the Strep infection was actually in her blood). Because a simple Strep infection went undiagnosed and untreated, the baby is blind, suffers from massive brain damage and will not enjoy a normal life and will be dependent on others for her most basic needs as long as she lives.

Outcome: Settled for an undisclosed amount.

Emily

Facts: This 47-year-old woman had a medical history of three C-sections and a hysterectomy. Because of persistent abdominal pain, which began following the hysterectomy, she complained to her gynecologist, Dr. X. He told her that the pain was from adhesions and that a routine outpatient procedure involving the insertion of a scope below the umbilicus would stop her pain (i.e., laparoscopy to free pelvic adhesions). On March 9, 1998, Dr. X performed the surgery in 35 minutes. During the surgery, Dr. X punctured her sigmoid colon. He failed to recognize what he had done so the surgery ended with the perforation in her colon undetected. Bowel contents contaminated her pelvis and jeopardized her health and life.

Within 24 hours Emily had developed a 103 degree temperature and felt severe abdominal pain. She called Dr. X for help, but he told her that her symptoms were to be expected. She asked for stronger pain medication, but he told her that would mask the symptoms. She could not sleep and repeatedly called Dr. X, who dismissed her complaints. By March 11, two days after the surgery, she was too weak and ill to be driven to the hospital by her husband so he called for an ambulance. In the emergency room, she gave a history of her surgery and explained her symptoms. She complained about abdominal pain, nausea and a high temperature. The emergency room personnel, after calling Dr. X, discharged her and advised her to call Dr. X if her condition worsened. On March 14, she was again rushed to the hospital after a neighbor had found her vomiting and in terrible shape. She was treated for dehydration and, finally, her bowel injury was recognized on March 17.

Because there was a delay in diagnosing the wound to her colon, her body had flooded with fecal matter (two liters of stool lay in her stomach) and part of her colon needed to be removed. A temporary colostomy was installed. She remained in the hospital until May 27. Her ordeal was not over yet as she required hospitalization on four subsequent occasions to address infections, fevers and stool draining from the area where the surgery occurred. She had to rely on artificial bowel functions until July, when the colostomy was reversed. She is now permanently at risk for future bowel obstructions.

Outcome: After a two week trial in June of 2000, the jury found in favor of the plaintiff and awarded her $1.5 million (this was reduced to $925,930 due to Maryland's limit on non-economic damages).

Doctor Y

Dr. Y is an orthopedic surgeon/hand surgeon, practicing in Baltimore. He has paid damages to at least five patients. Judgments against Dr. Y and cases that have resulted in settlements have included the following:

- Ashley[12] is a case filed in 1988 where Dr. Y performed two unnecessary surgeries on the patient's spine. It was settled for an undisclosed amount.
- Brianna is a case filed in 1990 where Dr. Y negligently performed a hip replacement procedure. It was settled for an undisclosed amount.
- Courtney is a case filed in 1997 where Dr. Y performed an unnecessary carpal tunnel release procedure that started a cascade of problems. He ordered follow-up procedures to fraudulently conceal the original negligence. As a result, the patient had twelve surgeries in nine years. It resulted in an arbitration award of almost $1.4 million.
- Sarah is a case filed in 1997 where Dr. Y negligently performed an operation on the patient's spine. It was settled for an undisclosed amount.
- Elizabeth is a case filed in 2002 where Dr. Y casted the arm of a young girl despite an obvious angular deformity in the arm. It was settled for an undisclosed amount.

Dr. Y has never been disciplined by the state of Maryland. There are no restrictions on his license. Dr. Y still has full privileges at several Baltimore area hospitals. He did lose privileges at one hospital many years ago. He can still get insurance to practice medicine.

Courtney

Facts: This attractive woman, now 54-years old, injured her left wrist in November of 1985 while employed as a drywall finisher. Following the injury, she saw an orthopedic surgeon who performed a left Dequervain's release of the sheath around the thumb ligament in early 1987. When she continued to complain of a painful wrist, her orthopedic surgeon referred her to Dr. Y, an orthopedic hand specialist, for a second opinion in September of 1987. She told Dr. Y that she was experiencing persistent pain and discomfort in her wrist. In the notes of his first examination of her, Dr. Y referred to a history of clicking sounds. During her trial testimony, she denied complaining of any such clicking. Furthermore, the notes of her first orthopedic surgeon, with whom she had an ongoing relationship for approximately one year before her visit to Dr. Y, contain no reference to any complaints of clicking. Dr. Y took x-rays of her left wrist (checking for a fracture) and also arranged for her to have an arthrogram (a procedure where dye is injected to determine if there is any ligament damage or other damage in the wrist joint.) On the visit following these tests, Dr. Y advised her that she needed surgery, thus leading her to believe that the x-ray and/or arthrogram were positive when, in fact, they were both negative (i.e. no evidence of fracture or ligament damage).

On October 26, 1987, Dr. Y performed an elaborate unnecessary surgery consisting of a carpal tunnel release, tri-scaphoid fusion, release of 1st dorsal compartment and radial styloidectomy. Plaintiff's medical expert, a distinguished orthopedic surgeon, testified that the appropriate medical treatment upon receipt of the negative test results is not surgery. Instead, conservative management and further diagnostic studies were indicated. This unnecessary surgery had significant adverse consequences for this patient and, according to the expert, triggered the whole cascade of problems that followed – twelve additional unnecessary and painful surgeries by Dr. Y over the course of nine years, including a total wrist replacement. The expert stated that the total wrist replacement was not an appropriate medical treatment and, not unexpectedly, it failed and, as a result, her wrist was eventually fused, leaving her with an immobile and non-functional wrist. Throughout this entire period, Dr. Y continually assured her that she was going to be great and the next surgery would be the one that allowed her to get back to work. In the fall of 1995, she was told by her worker's compensation carrier that it wanted an independent medical evaluation, and she was referred for a second opinion to another orthopedic surgeon. It was only after this examination that she learned she had been the victim of unnecessary and negligently performed surgeries. A medical malpractice lawsuit was filed against Dr. Y and, by agreement of the parties, the case was submitted to binding arbitration.

Outcome: Liability was stipulated by the defense. The arbitrator, a well-respected retired judge, ruled in her favor and awarded her $1,376,632. The formal finding was that Dr. Y committed fraud and deceit by covering up his unnecessary and negligently performed surgeries on Courtney's wrist. The arbitrator awarded past and future lost wages and past and future medical expenses of $966,232 and non-economic damages (i.e. pain and suffering) of $410,400. Eventually, after a variety of legal disputes were resolved, the parties settled for a total of $1,040,000.

Sarah

Facts: Sarah, age 47, was admitted to the hospital on September 22, 1994 for an anterior cervical disketomy and fusion at the C-3/4 level of the cervical spine**,** performed by Dr. Y. When Sarah woke up from the operation, she was suffering from paralysis on her right side. Dr. Y was advised of Sarah's condition and ordered x-rays of the cervical spine. He reviewed the x-rays but did not take any action until the next day when he had her transported to another hospital for a cervical spine MRI. The MRI disclosed that the bone plug that Dr. Y had inserted the previous day was displaced posteriorly and was now in the spinal canal. According to the expert's consultation report, her spinal cord appeared "markedly compromised at this level by the bone plug in question."

Sarah returned to the hospital where Dr. Y again operated on her, removing the bone graft, shortening it and re-inserting it. The operation didn't reverse the damage done by the previous day's procedure, however. As a result of the damage done to her spinal cord during the September 22 disketomy, she now suffers from Brown-Sequard Syndrome with right hemiplegia and mixed bilateral sensory loss. She remained in the hospital until October 20 when she was transferred to a rehabilitation hospital, where she was discharged on January 17 1995, readmitted on January 19, and finally discharged again on January 23, 1995.

Sarah is non-ambulatory because of a flaccid right hemibody and altered sensation. She has no functional use of her right upper and lower extremities and diminished sensation in the left upper and lower extremities. She has suffered from depression as a result of her debilitating and permanent injury.

In deposition testimony plaintiff's medical expert stated that Dr. Y had breached acceptable standards of care. Specifically, he stated that, "I believe a surgeon who does not know the dimensions of the spinal canal probably is not competent to do the surgery, and I don't believe he was competent to do the surgery. I think that's also reflected in his care of the patient postoperatively as well. It's a breach of the standard of care how he managed this patient in every respect except for the fact that he finally did get a CAT scan and then finally did reposition the graft. That was good, but too late obviously for this patient."

Outcome: Settled for an undisclosed amount.

Elizabeth

Facts: On June 5, 2001, Elizabeth, a healthy ten-year old, fell at school and was taken by her mother to the emergency room. X-rays showed a displaced fracture of the elbow and forearm. Dr. Y was the orthopedist on call that day. After being notified of this injury by telephone, Dr. Y decided that there was no immediate need for a careful setting and casting of the fracture. Instead, via telephone, Dr. Y guided the emergency room staff in the placement of a splint on her arm. He instructed Elizabeth and her mother to follow-up with him the following day. When Dr. Y saw her the next day, he failed to take new x-rays to determine whether the fracture had shifted. Instead, he reviewed the emergency room x-rays, adjusted her arm sling and left her arm in the splint. Dr. Y next saw her three weeks later, on June 27, at which time he took new x-rays and noted a 20 degree angular deformity. Despite that deformity, which Dr. Y should have known would not correct itself, he simply applied a long arm cast from her upper arm to her wrist.

The cast was removed on August 22. Elizabeth's arm had healed with a gross deformity that limited her strength and ability to rotate her palm up and down. When her mother questioned Dr. Y about the deformity, he told her that God would heal her arm over time. Her mother sought a second opinion from a medical specialist. New x-rays showed a 30 degree angulation. In order for the deformity to be corrected, Elizabeth's new doctor performed a surgery in which both of her forearm bones were re-broken, realigned and internally fixed with plates and screws. Fairly good alignment was achieved and she made a good recovery, although she now has some limitation in her strength and measurable limitation in her ability to pronate, or turn, her palm down, which has affected her ability to play basketball and use a keyboard.

A preeminent retired hand surgeon in Baltimore, was used as an expert by the plaintiffs. In his expert opinion, it was a breach of the standard of care for Dr. Y to not take new x-rays on June 6, 2001 and to place her in a long arm cast on June 27. He further believes that more probably than not, on June 27, her arm still would have been able to be reduced and aligned without surgery and after healing would have experienced virtually no limitations.

Outcome: Settled for an undisclosed amount.

Doctor Z

Dr. Z is an orthopedic surgeon practicing in Maryland. He has made payments to at least six patients. Judgments against Dr. Z and cases that have resulted in settlements have included the following:

- Anthony[13] is a case filed in 1989 where Dr. Z negligently performed arthroscopic surgery, disabling a patient's knee. It was settled for $30,000.
- Benjamin is a case filed in 1991 where Dr. Z made an incision on the wrong knee of a patient. It was settled for $4,000.
- Catherine is a case filed in 1991 where Dr. Z negligently applied a cast to a four-year old's arm resulting in deformity. It was settled for an undisclosed amount.
- Jessica is a case filed in 1991 where Dr. Z failed to appropriately treat an infection resulting from knee replacement surgery. It resulted in an arbitration award of $33,860.
- Emma is a case filed in 1995 where Dr. Z lacerated a patient's nerves during carpal tunnel surgery. It was resolved confidentially.
- Faith is a case filed in 2000 where Dr. Z negligently performed elbow surgery. It was resolved confidentially.

There are currently no restrictions on Dr. Z's license to practice medicine. Dr. Z still has privileges at several hospitals. He still has insurance to practice medicine.

Dr. Z has been disciplined once by the state of Maryland. Per Maryland law, filings of medical malpractice cases are automatically sent to the State Board of Physicians (previously the Board of Physician Quality Assurance, or BPQA). After receiving copies of filings in 1991 and 1992, BPQA requested that the Medical and Chirurgical Society of Maryland (Med-Chi) conduct a review of Dr. Z's practice. The review, dated August 18, 1994, found that the standard of care was not met in the care of three patients. On June 28, 1995, Dr. Z entered into a Consent Order with the Board placing him on probation for 36 months with the option to petition the Board to terminate the probation after two years. Conditions of the order that needed to be satisfied within the first year included: that Dr. Z complete a Board approved medical record keeping course, that he complete a Board approved course in orthopedic surgery and that he be subject to a peer review of his medical practice. Probation was terminated on September 10, 1997 after satisfactory completion of all requirements of the consent order.

Dr. Z has been sued five times since the termination of his probation (three cases are still pending) and he continues to provide substandard care to patients in Maryland. A Baltimore attorney who represented Emma and Faith filed a formal complaint against Dr. Z with the Board in 2001. He is currently under investigation, and as of a few months ago, was still being investigated by Med-Chi.

Emma

Facts: In March of 1994, a bright and articulate 46-year-old woman employed as a box assembler complained to her family physician that she was experiencing pain in both of her hands. She was referred to Dr. Z and first saw him on March 14, 1994. Dr. Z diagnosed bilateral carpal tunnel syndrome, which was work related. Dr. Z recommended an open carpal tunnel release, which was performed at the hospital on August 23 for her right hand and on her left hand on October 6. Carpal tunnel surgery is designed to relieve pressure on the nerves in the hand that is caused by a narrowing of the tunnel in the wrist through which the nerves travel. However, during the second surgery, rather than releasing the nerve, Dr. Z severed two of the three branches of the median nerve, which allows you to move and feel your thumb. Before the surgery, she had a completely normal thumb. After the surgery, she could not move or feel her thumb. As time progressed, an extremely painful lump developed in the palm of her left hand, which turned out to be a neuroma caused by the ends of her nerves trying to grow back together.

Emma complained to Dr. Z who told her that her symptoms were a normal part of recovery. Dr. Z failed to even record her complications in his notes from three follow-up visits in October and November. On her last visit, despite the fact that she could not feel or move her thumb, Dr. Z told her that she could return to full-time work on an assembly line. Upset that Dr. Z ignored the decreased sensation in her hand and her inability to use her thumb, she consulted her family physician who recommended that she seek a second opinion from another hand surgeon. She saw the new hand surgeon on November 21, 1994, who sent her for nerve conduction studies that showed two nerves had been cut during the surgery Dr. Z performed on her left hand. On December 14, she had to undergo another procedure on her left hand so her nerves could be reattached. The procedure was technically a success, although her hand will never return to normal.

This young woman underwent months of therapy, but she never regained normal strength or the use of her thumb. For years following the surgery, she wore a protective brace on her left hand to lessen the pain. Her employer kept her on in the office, but she always feared that she would lose her job because she was very limited in her ability to use her left hand. During this time she also struggled at home due to the loss of her husband, leaving her alone and having to do everything herself. Her hand has improved somewhat over the years, but it has taken a long time for her pain to decrease.

Outcome: Settled for an undisclosed amount on the first day of trial in October of 1996.

Catherine

Facts: On November 8, 1985, Catherine, only four-years old, fell and injured her left arm. She was taken to the hospital where she came under the care of Dr. Z. X-rays were taken that showed a severe displacement and angulation of the left humerus. Under these circumstances standards of care require that the child be given general anesthesia and the fracture be reduced. Only after the swelling is decreased and the fracture fragments reduced should the cast be applied. Dr. Z, however, attempted to reduce the fracture site by inadequate administration of a local anesthetic and pain reliever with closed manipulation and inappropriate application of a plaster cast. The cast was removed on December 9, 1985. A permanent orthopedic deformity as well as a growth disability had occurred. Catherine experienced physical pain and mental anguish and her ability to pursue a normal life has been affected.

Outcome: Settled for an undisclosed amount.

Faith

Facts: On October 20, 1999, Faith fell at her home, injuring her head and right elbow. She went to the emergency room of the hospital where she was treated by Dr. Z for a multi-part fracture of a bone in the tip of her elbow. Once her head injury stabilized, Dr. Z performed open reduction and internal fixation surgery on her elbow, choosing to use a screw, designed to be placed down the middle of the bone. Dr. Z did not successfully perform the surgery according to two medical experts used by the plaintiffs, both physicians specializing in orthopedic surgery. First, Dr. Z failed to properly and adequately reduce the fracture and return the bones of Faith's forearm to their correct anatomical alignment. Second, instead of placing the compression screw down the middle of the bone, Dr. Z placed the threaded portion of the screw completely out of the bone. To make matters worse, he did not notice these problems on post-surgery x-rays. Faith's arm was placed in a cast on November 3 despite x-rays showing that the ulna was still displaced and the fracture had not been reduced.

On a return visit on November 17, Faith complained to Dr. Z that there was swelling, bruising and discoloration on her arm. She also could not make a fist with her hand. She was in severe pain and could not move her arm very well. Dr. Z again took x-rays and assured her that the alignment of the fracture and placement of the screw were acceptable. On November 29, Faith returned to Dr. Z and complained of a burning sensation inside her cast in addition to the severe pain she was still experiencing. Dr. Z removed her cast and found that her skin was irritated. When the cast was removed, she found that she could not move her elbow at all – it was totally frozen at a 90° angle. Despite this fact, Dr. Z continued to reassure her that her elbow was healing well. On December 6, Faith visited Dr. Z again. This time, he finally recommended that the compression screw be removed. This happened on December 9.

Faith was reexamined by Dr. Z on December 13 and for the first time he reported a "slight" displacement in his notes. Afterwards, Dr. Z referred her to Dr. Y (one of the three doctors profiled in this section), who recommended a total elbow replacement. Faith decided to go to a surgeon of her own choice for another opinion, however, and he recommended surgery to attempt to fix the fracture of her elbow. This was the first time that she realized the mistakes that Dr. Z had made. On January 8, 2000, Faith underwent her third surgery, which did restore her elbow to correct anatomical alignment. However, because of the long time that her elbow had remained out of alignment, the scarring in the elbow joint continued to restrict her movement and give her pain. Faith ultimately underwent a fourth surgery, which removed scar tissue and allowed her some increased movement.

Today, Faith lives with pain and swelling in her elbow and limitation in movement, although she can now do the simple tasks such as combing her hair and applying makeup that she couldn't do for many months. The impact of Dr. Z's negligence has been particularly devastating to her since she is a single woman living alone with no one to rely on but herself.

Outcome: Settled for an undisclosed amount, on the fourth day of trial, in July of 2001.

Endnotes

[1] Greg Garland, "Medical Board Backs Reforms/Nonpunitive System for Reporting Errors Gets Panel's Support," *Baltimore Sun*, Sept. 9, 2001. See also: Stephanie Desmon, "Medical Reform Locked in Fight," *Baltimore Sun*, March 17, 2003.
[2] Sidney Wolfe, M.D., "Public Citizen's Health Research Group Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions in 2002," March 27, 2003. Available on Public Citizen's Web site at http://www.questionabledoctors.org/.
[3] *Id.*
[4] The Federation of State Medical Boards, in its Summary of 2001 Board Actions, reported that its Composite Action Index shows a sharp decrease in the ratio of disciplinary actions of all types to number of physicians in Maryland since 1998. The composite action ratio dropped from 6.98 in 1998 to 3.32 in 2001, a drop of 53 percent. Nationally, according to FSMB's Report, Maryland ranked 46th out of the 59 medical boards surveyed that had at least 1,000 members. FSMB Summary of 2001 Board Actions, April 9, 2002.
[5] Department of Health and Mental Hygiene, Health Professional Boards and Commission, State Board of Physician Quality Assurance, State Board of Nursing, Office of Legislative Audits, Department of Legislative Services, Maryland General Assembly, October 2002.
[6] David Snyder and Jo Becker, "Md. Lawmakers Take Aim at Medical Board," *Washington Post*, March 21, 2003.
[7] MD Code, Health Occupations, § 14-101 et seq. (Acts 2003, c.252, §1 eff. July 1, 2003).
[8] John O'Connor, "MedChi, Liquor Store Lobbyist Has Successful General Assembly Session," *Daily Record*, April 11, 2003.
[9]Federation of State Medical Boards, Policy Documents, Uniform Standards and Procedures, Disciplinary Terminology and Processes, 1. Standard of proof required in disciplinary procedures. http://www.fsmb.org/
[10] Interview with Margaret Anzalone, Deputy Director of the Maryland Board of Physicians, by Conor Kenny, January 9, 2004.
[11] The names of Dr. X's victims have been changed.
[12] The names of Dr. Y's victims have been changed.
[13] The names of Dr. Z's victims have been changed.