

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2023-047

In the Matter of

Richard E. Altman, M.D.

CONSENT ORDER

Pursuant to G.L. c. 30A, § 10, Richard E. Altman, M.D. ("Respondent") and the Board of Registration in Medicine ("Board") (hereinafter referred to jointly as the "Parties") agree that the Board may issue this Consent Order to resolve the above-captioned adjudicatory proceeding. The Parties further agree that this Consent Order will have all the force and effect of a Final Decision within the meaning of 801 C.M.R. 1.01(11)(d). The Respondent admits to the findings of fact specified below and agrees that the Board may make the conclusions of law and impose the sanction set forth below in resolution of investigative Docket number 19-525.

Findings of Fact

1. The Respondent graduated from the University of Vermont's College of Medicine in 1988. He is certified by the American Board of Medical Specialties in Urology. The Respondent has been licensed to practice medicine in Massachusetts under certificate number 79286 since 1994.

2. On February 2, 2018, a malpractice payment was made on Respondent's behalf to settle a complaint filed against the Respondent regarding his care treatment of Patient RM.

3. On July 20, 2018, a malpractice payment was made on Respondent's behalf to

settle a complaint filed against the Respondent regarding his care treatment of Patient JS.

Patient RM

4. On February 11, 2013, Patient RM presented to Respondent with a 2 cm right lower pole ("RLP") stone with mild RLP hydronephrosis.
5. Patient RM's lab results were positive for e. coli.
6. Respondent, who was aware of the positive lab results, decided to leave the urinary tract infection ("UTI") untreated because Patient RM was asymptomatic.
7. The American Urological Association's Guidelines recommend that a patient whose preoperative evaluative urine culture is positive for a UTI be prescribed appropriate antibiotic therapy.
8. On March 18, 2013, Respondent performed a right percutaneous nephrolithotripsy on Patient RM.
9. During the procedure, Respondent could not find the stone. He was unsure if it was stuck in another infundibulum or another collecting system area. But, due to bleeding and oozing, after 15 minutes of looking, Respondent elected to stop the procedure.
10. Respondent left a catheter in place, so he could possibly have a second look in the future.
11. Patient RM was sent to the PACU in stable condition.
12. In the PACU, Patient RM was noted to have significant postoperative distress. An urgent CT abdomen and pelvis scan was performed revealing fluid collecting around the kidney with dislodged nephrostomy catheter that was outside the renal collecting system in the perinephric space.
13. Patient RM was reintubated for respiratory distress and transferred to the Intensive Care Unit ("ICU") where she continued to show signs of sepsis requiring vasopressors.

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14. Patient RM continued to decline clinically and ultimately died on March 20, 2013.
15. Respondent's treatment of Patient RM fell below the standard of care in two ways.
16. First, Respondent failed to follow the American Urological Association's Guidelines' recommendation that a patient, whose preoperative evaluative urine culture is positive for a urinary tract infection, be prescribed appropriate antibiotic therapy.
17. Second, when the percutaneous nephrostomy catheter was noted to be outside of the collecting system and subsequently removed, Respondent did not place a ureteral stent.

Patient JS

18. Patient JS presented to Respondent on February 14, 2012, for a 6 mm left upper ureteral stone with hydronephrosis. After discussing surgical options, they decided to take a conservative non-surgical approach.
19. However, the next day, one of Respondent's colleagues placed a ureteral stent after Patient JS presented to the ER with an increase in his symptoms.
20. Patient JS elected to schedule a ureteroscopic stone procedure.
21. On February 27, 2012, Respondent performed a cystoscopy, left ureteroscopy, laser lithotripsy, and placed a stent.
22. During the procedure, the stone was very adherent to the wall of the ureter, but Respondent felt that when he was finished, he had lasered the great majority of the stone.
23. Respondent felt there was a lot of edema in the area and elected to leave a stent in for about three weeks, which Respondent removed without difficulty on March 16, 2012. A follow-up appointment was scheduled for early June. Respondent also planned to see Patient JS one year later.
24. Patient JS canceled his June follow-up appointment. Apparently, the cancellation

was never relayed to Respondent.

25. He returned for his one-year follow-up appointment on April 3, 2013. In response to his complaints, Respondent ordered a renal ultrasound which showed left hydronephrosis.

26. A CT scan was performed on April 7, 2013, which confirmed hydronephrosis, but also raised the question of a retained object.

27. Respondent met with Patient JS on April 10, 2013, to discuss the CT findings. They discussed the need for a percutaneous procedure.

28. Later, when Respondent's office called Patient JS to confirm the surgery appointment, Patient JS stated he would go elsewhere for further treatment.

29. On April 26, 2013, Patient JS underwent a procedure at another medical facility where an approximately 6 cm segment of wire was removed from the left renal collecting system in his left kidney.

30. The retained segment of wire was left by Respondent during his February 27, 2012 procedure.

31. The facility noted that Patient JS' left kidney appeared to be nonfunctioning.

32. Respondent failed to meet the standard of care during the surgical procedure he performed on February 27, 2012 when he failed to identify and remove a foreign object that was placed in the patient's renal collecting system during surgery.

Mitigation

33. Respondent acknowledges that his treatment of Patients RM and JS was suboptimal. In response, Respondent has made changes to his practice.

34. Regarding Patient RM, Respondent has changed his practice in terms of how he approaches similar cases in the hope of minimizing risk to his patients.

35. First, Respondent has changed his practice regarding the preoperative treatment of

UTIs. He now treats asymptomatic bacteria with antibiotics in an effort to sterilize urine before clearing a patient for surgery.

36. Second, Respondent has changed his practice to now have a percutaneous nephrostomy tube placed by the Interventional Radiologist ("IR") two to three days ahead of a scheduled surgery, which: results in less bleeding once a track is established; makes balloon dilation easier with resulting better visualization and less chance for seeding the bloodstream; and requires less time in the OR and less anesthesia time for the patient. Respondent now has the IR get a urine culture from the calyx or renal pelvis at the time the tube is placed and have those culture results back by the time Respondent goes to surgery, allowing Respondent to change or tailor his antibiotic choice as needed.

37. Third, Respondent gives a great deal of thought to whether he should just observe asymptomatic patients rather than opt for surgical intervention.

38. Regarding Patient JS, Respondent's office has changed its practice regarding follow-up visit cancellations. Now, whenever an established patient calls to cancel an upcoming office visit, the telephone encounter is sent to the physician, who can check the chart to see if the patient needs to be contacted to reschedule. Additionally, if a patient is unable to be rescheduled by telephone, a certified letter is sent. If a patient refuses to reschedule a cancelled appointment, a certified letter is sent advising the patient of the need for follow up.

39. Since Patient JS's procedure, Respondent has educated himself on the risk in small incidences of lasered wires or the laser wire itself breaking when performing a ureteroscopic procedure.

Conclusions of Law

- A. Respondent engaged in negligent conduct on two occasions in violation of G.L. c. 112, § 5, eighth par. (c) and 243 C.M.R. 1.03(5)(a)(3).

B. Respondent violated 243 C.M.R. 1.03(5)(a)(17).

Order

The Respondent's medical license is hereby admonished. This sanction is imposed for each violation of law listed in the Conclusions section and not a combination of any or all of them.

Execution of this Consent Order

Complaint Counsel and the Respondent agree that the approval of this Consent Order is left to the discretion of the Board. The signature of Complaint Counsel the Respondent and the Respondent's counsel are expressly conditioned on the Board accepting this Consent Order. If the Board rejects this Consent Order, in whole or in part, then the entire document shall be null and void; thereafter, neither of the parties nor anyone else may rely on these stipulations in this proceeding.

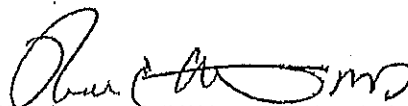
As to any matter in this Consent Order left to the discretion of the Board, neither the Respondent, nor anyone acting on his behalf, has received any promises or representations regarding the same.

The Respondent waives any right of appeal that he may have resulting from the Board's acceptance of this Consent Order.

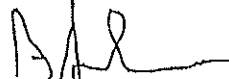
The Respondent shall provide a complete copy of this Consent Order within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which the Respondent practices medicine; any in- or out-of-state health maintenance organization with whom the Respondent has privileges or any other kind of association; any state agency, in- or out-of-state, with which the Respondent has a provider contract; any in- or out-of-state medical employer, whether or not the Respondent

practices medicine there; the state licensing boards of all states in which the Respondent has any kind of license to practice medicine; the Drug Enforcement Administration Boston Diversion Group; and the Massachusetts Department of Public Health Drug Control Program. The Respondent shall also provide this notification to any such designated entities with which the Respondent becomes associated in the year following the date of imposition of this admonishment. The Respondent is further directed to certify to the Board within ten (10) days that the Respondent has complied with this directive.

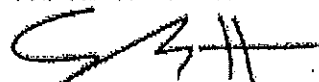
The Board expressly reserves the authority to independently notify, at any time, any of the entities designated above, or any other affected entity, of any action it has taken.


Richard E. Altman, M.D.
Licensee

10/24/2023
Date



Anthony Abeln, Esq.
Counsel for Licensee

10/24/23
Date


Erik R. Bennett, Esq.
Complaint Counsel

10/26/2023
Date

So ORDERED by the Board of Registration in Medicine this 21st day of December, 2023


Julian N. Robinson, M.D.
Board Chair