

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2022-023

In the Matter of

MATTHEW ROGALSKI, M.D.

CONSENT ORDER

Pursuant to G.L. c. 30A, § 10, Matthew Rogalski, 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 CMR 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 No. 17-149.

Findings of Fact

1. The Respondent graduated from Wake Forest University School of Medicine in 2005. The Respondent is board-certified in Obstetrics and Gynecology. He has been licensed in Massachusetts since September 25, 2013 under certificate number 251925. He works for Acadia Health at its Woonsocket, Rhode Island and Fall River, Massachusetts locations. The Respondent treated Patients A to F at Sturdy Memorial Hospital.

Patient A

2. Patient A was born in 1965.

3. Patient A was on an oral contraceptive (OCP) and was suffering from hypertension.

4. On September 10, 2015, Patient A consulted with the Respondent. At the time, Patient A was 50 years old and having menopausal symptoms. She had previously had an endometrial ablation performed by another provider.

5. On October 5, 2015, for purposes of contraception, the Respondent attempted an Essure procedure. The Essure procedure was unsuccessful.

6. On October 18, 2015, the Respondent saw Patient A. Patient A had stopped her OCP and indicated that her most recent menses had been "heavy" and that she did not want to continue to have long, heavy bleeding. The Respondent did not document a discussion with Patient A about a Mirena IUD or other contraceptive options. At the end of this visit, the Respondent's documented plan was to perform a hysterectomy with a removal of Patient A's fallopian tubes.

7. On November 19, 2015, the Respondent performed a hysterectomy with the removal of Patient A's fallopian tubes and ovaries.

8. On November 20, 2015, Patient A was discharged from the hospital.

9. On November 30, 2015, Patient A called the Respondent's office with pain and fever. The Respondent saw Patient A later that day. A transabdominal ultrasound showed 102/26 mm of free fluid.

10. On December 1, 2015, Patient A called the Respondent's office with a temperature of 100.8. Patient A was on Motrin which may lower a temperature. The Respondent reviewed the labs and advised her to call if her temperature went above 101.

11. On December 3, 2015, Patient A was readmitted to the hospital with a temperature of 101.6 and a CT scan finding of a 6.5cm fluid collection in the pelvis.

12. On December 4, 2015, Patient A was taken to the operating room and underwent an incision and drainage of a vaginal cuff abscess. She was also treated with IV antibiotics. Culture of the fluid from the abscess, which was pending at discharge, showed E. coli, Enterococcus, Klebsiella, Clostridia, Peptostreptococcus and Morganella morganii.

13. On December 7, 2015, Patient A was discharged home.

14. The Respondent failed to follow the standard of care as to his care of Patient A in the following ways:

a. The Respondent should have explored or attempted other treatments for the patient's condition before performing a hysterectomy on this patient.

b. The Respondent delayed appropriate treatment for a post-operative abscess.

Patient B

15. Patient B was a female born in 1969.

16. Patient B had irregular perimenopausal and then postmenopausal bleeding.

17. In May 2015, labs indicated that Patient B might be postmenopausal.

18. In September 2015, Patient B had an episode of bleeding with benign pathology.

19. On October 6, 2015, despite the fact that the bleeding had subsided and pathology was benign, the Respondent offered Patient B an endometrial ablation.

20. On October 8, 2015, the Respondent spoke with Patient B and the Respondent's plan changed from performing an endometrial ablation to performing a hysterectomy because Patient B wanted definitive therapy.

21. On November 19, 2015, the Respondent performed a hysterectomy on Patient B during which he caused an injury to the patient's bladder. Pursuant to hospital protocol, the Respondent had another specialist assist him with the repair.

22. In the months after the injury, Patient B had urinary issues.

23. The Respondent failed to follow the standard of care as in that the Respondent should have explored or attempted other treatments for the patient's condition before performing a hysterectomy.

Patient C

24. Patient C is a female born in 1967.

25. Patient C suffered from a variety of conditions including nocturia, mild incontinence, and an episode of post-menopausal bleeding.

26. Patient C saw Respondent on May 17, 2016 and assessed that she had "benign endometrial polyp and premenstrual endometrium."

27. On August 12, 2016, the Respondent performed a laparoscopically assisted vaginal hysterectomy on Patient C.

28. The Respondent failed to follow the standard of care as to his care of Patient C in that the Respondent should have explored or attempted other treatments for the patient's condition before performing a hysterectomy.

Patient D

29. Patient D was a female born in 1965.

30. On or about October 27, 2015, the Respondent evaluated Patient D for a pink, watery discharge of three weeks duration. Patient D was obese and had two prior C-sections.

31. On October 27, 2015, the Respondent performed hysteroscopy and biopsy on Patient D. Pathology findings suggested a potential lack of progestin.

32. On November 18, 2015, Patient D was given information about the following options: Mirena IUD, endometrial ablation, and hysterectomy.

33. Patient D was not treated with progestin.

34. On December 14, 2015, Respondent documented that Patient D had “fairly constant bleeding” and was taking iron for fatigue. He discussed various treatment options with her and she opted for definitive treatment of her bleeding.

35. On January 21, 2016, the Respondent performed a laparoscopically assisted vaginal hysterectomy on Patient D.

36. The Respondent failed to follow the standard of care as to his care of Patient D in the following ways:

- a. The Respondent failed to treat Patient D with progestin.
- b. The Respondent should have explored or attempted other treatments for the patient’s condition before performing a hysterectomy.

Patient E

37. Patient E was a female born in 1962.

38. On March 17, 2017, the Respondent consulted with Patient E for high grade squamous epithelial lesion.

39. On April 18, 2017, the Respondent performed a loop electrical excision procedure (LEEP) on Patient E. The Respondent caused an incidental entry into the peritoneal cavity from through the posterior vagina. The Respondent performed a repair of the vaginal injury and a

subsequent laparoscopy to inspect for additional injury to the bowel, blood vessels, or other organs. The Respondent concluded that there were no such additional injuries.

40. Patient E was discharged the same day as the operation. After discharge, she called the night of the surgery with increased pain and gas but reported no temperature elevation and was not seen.

41. On April 19, 2017, Patient E called again the next day with worsening symptoms and was referred to the ED where a gynecologist diagnosed her with a bowel perforation and peritonitis.

42. Three months after the initial LEEP, the Respondent notified the patient that his LEEP had been insufficient for diagnosis, and she needed to see a gynecological oncologist for further surgery.

43. The Respondent failed to follow the standard of care as to his care of Patient E in the following ways:

- a. The Respondent did not have a general or colorectal surgeon assist him perform the initial laparoscopy and inspection of the bowel which missed the injury.
- b. Post-operatively, the patient had a very high risk for an injury to the bowel but was not seen the night of surgery when she called complaining of increased pain and gas, two signs of potential bowel injury.

Patient F

44. Patient F is a female born in 1961.

45. On December 30, 2014, the Respondent began treating Patient F. On that day, the Respondent saw Patient F for a routine examination and noted the patient's co-morbidities.

46. The Respondent followed Patient F for menopausal symptoms including decreased libido and treated with hormone replacement therapy.

47. On August 10, 2016, Patient F called complaining of bloating, gastrointestinal issues and back pain.

48. On August 23, 2016, Patient F had pelvic pain after a colonoscopy and expressed concern for pelvic inflammatory disease (PID). Patient F also had positive lab results for *Gardenella vaginalis*.

49. Over the course of the rest of the month, the Respondent prescribed Patient F multiple antibiotics which can cause side effects such as diarrhea. She continued to have pain and was prescribed Tramadol without a documented conversation with the Respondent.

50. The Respondent obtained an MRI which showed a suggestion of adenomyosis, a condition which does not usually cause pain in menopause, and atrophic ovaries which are normal in menopause. Despite an MRI that showed only adenomyosis and the possibility that her gastrointestinal issues resulted from the multiple antibiotics, the Respondent planned a hysterectomy based in part on Patient F's history of pain.

51. On October 4, 2016, at her pre-op visit, Patient F was feeling better on a new hormone replacement regimen, as well as Neurontin and Tramadol for pain. Despite her improved condition, the Respondent made the decision to proceed with the hysterectomy for low back pain.

52. On October 21, 2016, the Respondent performed the hysterectomy. The pre-operative diagnoses on the operative note were menorrhagia, dysmenorrhea, and adenomyosis.

53. The Respondent failed to follow the standard of care as to his care of Patient F in that he should have explored or attempted other treatments for the patient's condition before performing a hysterectomy.

Hospital and Rhode Island Discipline

54. On May 23, 2017, Sturdy Memorial Hospital Revoked the Respondent's gynecological privileges, but left his obstetric privileges intact.

55. In May 2019, the Respondent was hired by Landmark Medical Center (Landmark) as an employed obstetrician and gynecologist. He previously had been moonlighting for Landmark beginning in 2013.

56. On January 8, 2020, the Rhode Island Department of Health disciplined the Respondent based on the actions taken by Sturdy Memorial Hospital.

57. On October 22, 2020, Landmark temporally suspended the Respondent due to issues surrounding his care to one patient.

58. On March 25, 2021, the Respondent resigned from Landmark during Landmark's investigation of his care to said patient.

59. On December 8, 2021, the Rhode Island Department of Health disciplined the Respondent based on Landmark's actions.

Conclusion of Law

The Respondent has violated G.L. c. 112, § 5, eighth par. (c) and 243 CMR 1.03(5)(a)3 by engaging in conduct that places into question the Respondent's competence to practice medicine including practicing medicine with negligence on repeated occasions.

Sanction and Order

The Respondent's license is hereby REPRIMANDED. A license restriction is also imposed pursuant to M.G.L. c. 112, s. 5A and 243 C.M.R. 1.05(7), that prohibits the Respondent from engaging in the surgical practice of obstetrics and gynecology in an operating room setting, in an ambulatory care center, and/or in a hospital, without petitioning the Board for approval to do so, subject to any conditions that the Board, in its discretion, may impose.

This sanction is imposed for each violation of law listed in the Conclusion 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 with all exhibits and attachments 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 s/he practices medicine; any in- or out-of-state health maintenance organization with whom s/he has privileges or any other kind of association; any state agency, in- or out-of-state, with which s/he has a provider contract; any in- or out-of-state medical employer, whether or not s/he practices medicine there; the state licensing boards of all states in which s/he 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 s/he becomes associated for the duration of the Practice Restriction. The Respondent is further directed to certify to the Board within ten (10) days that s/he has complied with this directive.

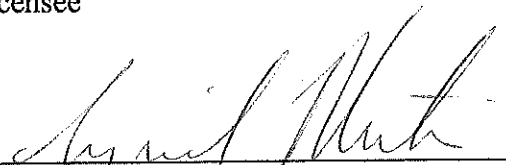
The Board expressly reserves the authority to independently notify, at any time, any of the entities designated above, or any other affected entity, of any action it has taken.



Matthew Rogalski, M.D.
Licensee

3/25/22

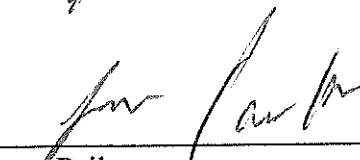
Date



Ingrid Martin
Attorney for the Licensee

3/30/2022

Date



James Paikos

4/14/2022

Date

Complaint Counsel

So ORDERED by the Board of Registration in Medicine this 4th day of August
2022.



Julian Robinson, M.D.
Board Chair