

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2022-023

In the Matter of)
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MATHEW ROGALSKI, M.D.)
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STATEMENT OF ALLEGATIONS

The Board of Registration in Medicine (Board) has determined that good cause exists to believe the following acts occurred and constitute a violation for which a licensee may be sanctioned by the Board. The Board therefore alleges that MATHEW ROGALSKI, M.D. (Respondent) has practiced medicine in violation of law, regulations, or good and accepted medical practice as set forth herein. The investigative docket number associated with this order to show cause is Docket No. 17-149.

Biographical Information

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.

Factual Allegations

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.

Legal Basis for Proposed Relief

A. Pursuant to G.L. c. 112, §5, eighth par. (c) and 243 CMR 1.03(5)(a)3, the Board may discipline a physician upon proof satisfactory to a majority of the Board, that he engaged in conduct that places into question the Respondent's competence to practice medicine, including but not limited to negligence on repeated occasions.

The Board has jurisdiction over this matter pursuant to G.L. c. 112, §§ 5, 61 and 62. This adjudicatory proceeding will be conducted in accordance with the provisions of G.L. c. 30A and 801 CMR 1.01.

Nature of Relief Sought

The Board is authorized and empowered to order appropriate disciplinary action, which may include revocation or suspension of the Respondent's license to practice medicine. The Board may also order, in addition to or instead of revocation or suspension, one or more of the following: admonishment, censure, reprimand, fine, the performance of uncompensated public service, a course of education or training or other restrictions upon the Respondent's practice of medicine.

Order

Wherefore, it is hereby **ORDERED** that the Respondent show cause why the Board should not discipline the Respondent for the conduct described herein.

By the Board of Registration in Medicine,



Julian N. Robinson, M.D.
Board Chair

Date: August 4, 2022