**THE COMMONWEALTH OF MASSACHUSETTS**

Middlesex, ss. **Division of Administrative Law Appeals**

**Board of Registration in Medicine,**

 Petitioner

 v. Docket No. RM-17-1003

 Dated: September 6, 2019

**Hoang N. Pham, M.D.,**

 Respondent

**Appearance for Petitioner:**

Lawrence R. Perchick, Esq.

Complaint Counsel

Board of Registration in Medicine

200 Harvard Mill Square, Suite 330

Wakefield, MA 01880

**Appearance for Respondent:**

Kenneth R. Kohlberg, Esq.

Law Offices of Kenneth R. Kohlberg

30 Monument Square, Suite 110

Concord, MA 01742

**First Administrative Magistrate:**

James P. Rooney

**SUMMARY**

It is recommended that the Board of Registration in Medicine’s motion for summary suspension of doctor for violating the standard of care in managing the chronic diseases of four of his patients be denied. The Board failed to prove by a preponderance of the evidence that the doctor’s continued practice presents an immediate and serious threat to the public health.

**RECOMMENDED DECISION ON SUMMARY SUSPENSION**

 On November 22, 2017, the Board of Registration in Medicine issued a Statement of Allegations against Hoang N. Pham, M.D., alleging that he engaged in substandard care of five patients while he was employed with the Family Health Care Center of Worcester. On the same day, acting under authority granted it at 243 CMR 1.03(11)(a), the Board summarily suspended Dr. Pham’s license because his continued practice was an “immediate and serious threat to the health, safety, and welfare of the public.”[[1]](#footnote-1) The Board relied on documents attached to a motion by complaint counsel seeking the doctor's suspension. The documents included: (1) an affidavit of Board investigator Susan Dye, (2) a letter reporting a negative peer review of Dr. Pham, submitted after he left the Family Health Center, and (3) an expert’s report written by Andrew Angel, M.D., summarizing his review of the patient’s medical records.

 Dr. Pham, who lives and works in Maryland, waived his right to an immediate hearing, but nonetheless continued to request a hearing on summary suspension, which I scheduled. Prior to the hearing, the Board stated that it was no longer proceeding with any of the allegations pertaining to Patient AS, thereby leaving the allegations pertaining to four other patients at issue.

I held a three-day hearing on the summary suspension from June 6, 2018 through June 8, 2018 at the Division of Administrative Law Appeals, 1 Congress Street, Boston. The hearing was transcribed by a court reporter. I admitted into evidence 107 exhibits offered by the Board and eleven exhibits offered by Dr. Pham.[[2]](#footnote-2) On June 6th, the Board presented testimony of nurse practitioner Joy O’Brien, a former colleague, and Dr. Pham. On June 7th, the Board presented testimony of its expert, Dr. Angel. On June 8th, Dr. Pham testified on his own behalf and presented testimony of Dr. Gregory Culley, his former supervisor, and Dr. Mark Friedman, his expert. On the same day, the Board presented the testimony of its investigator, Ms. Dye.

At the outset of the hearing, Dr. Pham presented a motion in limine to limit the testimony of nurse practitioner Joy O’Brien. I allowed the motion to the extent that Ms. O’Brien was limited to testifying about the patients she treated and her review of the medical records that formed the bases for the incident reports she submitted. She was not permitted to testify about a physician’s standard of care. Dr. Pham also presented a motion in limine concerning Ms. Dye’s affidavit. I denied the motion, but stated I would give minimal weight to any comments in the affidavit about patients other than the four at issue.

The Board presented a motion in limine to bar the testimony of Dr. Culley, Dr. Pham’s former supervisor and former Chief Medical Officer at the Family Health Center. I denied the motion on the ground that Dr. Culley’s testimony was potentially probative of any basis, or lack thereof, for the assertion that Dr. Pham is a serious and immediate threat to patients of Massachusetts. The Board also moved to bar the affidavit of Dr. Ramin Mazari, Dr. Pham’s supervisor at his current job in Maryland, on the basis that he was unavailable to be cross-examined as to the truthfulness of the statements in the affidavit. I allowed the motion to strike the affidavit, but allowed Dr. Mazari to testify by phone if he was able to do so. In the end, he did not do so.

Both parties submitted post-hearing briefs on August 3, 2018.

**Findings of Fact**

Based on the testimony and evidence presented, and the reasonable inferences drawn from them, I make the following findings of fact:

1. Hoang Pham was born in Vietnam in 1978. He graduated from medical school, in Vietnam, in 2002. In September 2003, he moved to the United States. (Pham Tr. at 830, 835.[[3]](#footnote-3))
2. In 2009, Dr. Pham completed a three-year medical residency with St. Vincent’s Hospital and UMass Medical Center in Worcester, MA. That same year, Dr. Pham obtained his license to practice medicine in Massachusetts. He has been board certified in Internal Medicine since August 2009. (Pham testimony - Tr. at 264-265; 837-838.)
3. From August 2009 to July 2016, Dr. Pham worked at the Family Health Center of Worcester, a community health center. In July 2016, he left the Center and moved to Maryland because his wife accepted a job offer in that state. (Pham testimony - Tr. at 265-266.)
4. Since September 1, 2017, Dr. Pham has been working at Patient First, which is an urgent care center in Maryland. (Pham testimony - Tr. at 268-269.)
5. Joy O’Brien is a Nurse Practitioner (NP) who worked with Dr. Pham at the Family Health Center from December 2014 to July 2016. After Dr. Pham left, NP O’Brien took over the care of about 500 of Dr. Pham’s patients. (O’Brien testimony - Tr. at 56-57.)

*Family Health Care Center of Worcester*

1. During much of Dr. Pham’s tenure at the Family Health Center, the clinic’s Chief Medical Officer, Dr. Gregory Culley, incorporated “integrative medicine” into the clinic’s approach. “Integrative medicine” combines traditional medicine with non-traditional medicine such as acupuncture, dietary modifications, exercises, and herbs. Dr. Pham and another physician, Dr. Melissa Rathmell, practiced integrative medicine. (Pham testimony - Tr. at 267; Culley testimony - Tr. at 591.)
2. Dr. Pham’s supervisor at the Family Health Center enrolled him in an acupuncture course offered at Harvard Medical School. Dr. Pham obtained an acupuncturist certificate. (Culley testimony - Tr. at 592.)
3. Dr. Pham worked at the Family Health Center’s Webster Square clinic, which was a satellite clinic. The Webster Square clinic employed two M.D.s, one doctor of osteopathy, and one nurse practitioner. (O’Brien testimony - Tr. at 64.)
4. The Webster Square clinic did not perform blood draws. Patients had to go to Queen Street, the main Family Health Center location, to get their blood drawn. Queen Street had to send blood samples to UMass Memorial Hospital for analysis. It took about ten minutes to drive between Webster Square and Queen Street. (Pham testimony - Tr. at 857-858.)
5. The UMass test results were accessible to FHCW medical providers through NextGen, their shared electronic medical record system. (O’Brien testimony - Tr. at 101.) However, because the computer systems of the two institutions were not integrated, lab results from UMass did not necessarily make it into the Family Health Center’s computerized medical records. (Pham testimony – Tr. at 651.)
6. A typical NextGen screen at the Family Health Center included an automatically-populated field and a note-taking field with the option of free text. NextGen had unreliable infrastructure. (O’Brien testimony - Tr. at 71-73.)
7. Dr. Pham had a panel of between 1600 and 2000 patients at FHCW. He saw an average of eighteen to twenty patients per day, and up to twenty-five patients on his busiest days. (Pham testimony - Tr. at 269-271.)
8. The Family Health Center allotted providers twenty minutes for each regular patient visit. (O’Brien testimony - Tr. at 95; Pham testimony - Tr. at 756.)
9. From November 2011 to September 2015, Dr. Culley was responsible for supervising 52 medical providers. Dr. Culley supervised Dr. Pham by holding monthly meetings with him. He was initially surprised at the speed with which Dr. Pham completed his medical documentation, but his review demonstrated to him that the records prepared by Dr. Pham were adequate. Dr. Culley did not encounter any problems with Dr. Pham’s treatment of patients and found his work to be excellent.[[4]](#footnote-4) (Culley testimony - Tr. at 582-586; Resp. Ex. 7.)
10. The clinic doctors conducted quarterly peer reviews of each other’s medical documentation. None of these reviews resulted in any criticism of Dr. Pham’s medical documentation. (Culley testimony - Tr. at 582-586.)

*Chronic Disease Management*

1. One of a primary care physician’s key roles is chronic disease management. Many of the Family Health Center’s patients suffered from chronic diseases. Chronic diseases include diabetes, chronic kidney disease, gout, gastroesophageal reflux disease, hypothyroidism, and hypertension. (O’Brien testimony - Tr. at 75-76; Angel testimony - Tr. at 343-344.)
2. Since there are no cures for chronic diseases, chronic disease management involves treating the symptoms of each disease and treating the underlying conditions that can precipitate it, for example, as to kidney disease, controlling diabetes and high blood pressure. It also consists of frequent follow-up and, to some extent, weight loss, exercise, and a healthy diet. The physician sometimes consults with the specialists who are also treating the patient. (Pham testimony – Tr. 276; Angel testimony – Tr. at 342-344; Friedman testimony - Tr. at 618.)
3. During each visit for chronic disease management, a primary care physician should take the patient’s vital signs, perform a physical exam, review laboratory test results, and speak with the patient. The physician should document the patient’s vitals, medications, assessment, and plan. (Angel testimony - Tr. at 347-348.)
4. Dr. Pham cared for patients with chronic diseases by monitoring patients’ medical problems, providing frequent follow-up, managing patients’ medications, and encouraging patients to be compliant with diet, exercise, and take their medications. (Pham testimony - Tr. at 273.)

**Patient AB**

1. Patient AB is an Afro-Caribbean male in his fifties. He is a long-term smoker with a medical history of dyslipidemia, hypertension, type 2 diabetes, and chronic kidney disease [“CKD”]. (Pet. Exs. 7, 8.)
2. Before May 2014, another physician at the Family Health Center, Dr. Tran, was Patient AB’s primary care physician. (Pet. Exs. 1-6.)
3. On May 22, 2014, Dr. Pham became Patient AB’s primary care physician. (Pet. Ex. 7.)
4. The standard of care for the average primary care physician treating a patient’s CKD is to prescribe medications for the precipitating factors causing kidney dysfunction, encourage medication compliance, and assess for other factors, such as being overweight or having an unhealthy diet. There is no cure for CKD, so the physician’s role is limited to slowing CKD’s progression. (Angel testimony - Tr. at 350, 363-364, 389; Friedman testimony - Tr. at 639-641.) The physician managing a patient’s CKD is to follow the patient’s test results, help the patient maintain a healthy blood pressure, and refer the patient to a nephrologist when necessary. Blood tests should include, at the minimum, blood urea nitrogen [“BUN”], serum creatinine, glomerular filtration rate [“GFR”], and microalbumin. (Pham testimony - Tr. at 276; Angel testimony - Tr. at 365, 367; Friedman testimony - Tr. at 650.)
5. Creatinine is “is a chemical waste product that [is] produced by [one’s] muscle metabolism.”[[5]](#footnote-5) A normal creatinine is 0.6 to 1.2 mg/dL for males. GFR is a “measure of how well [the] kidneys filter blood.”[[6]](#footnote-6) A GFR of 60 or greater is normal. (Pet. Ex. 5.)
6. Patients with both diabetes and CKD are more likely to have elevated creatinine levels. Medications used to treat diabetes may also impact creatinine levels. (Friedman testimony - Tr. at 639.)
7. An average primary care physician meets the standard of care if he obtains, or assures that another qualified physician obtains, a patient’s kidney function test results within two months after the patient’s initial diagnosis with stage 3b CKD. (Angel testimony - Tr. at 376-377.)
8. Patient AB was on either oral diabetes medications or injectable insulin, sometimes both, while he was under Dr. Pham’s care. (Pet. Exs. 6-24.)
9. Dr. Pham was treating Patient AB’s hypertension by prescribing him various standard blood pressure medications, including Losartan and Lisinopril. (Pet. Exs. 7-28.)
10. While under Dr. Pham’s care, Patient AB was also seeing Dr. John Lock (endocrinologist), Dr. Alexander Berry (urologist), and Dr. Marie Sosa (nephrologist). (O’Brien testimony - Tr. at 160; Pet. Exs. 10, 11, 15, 20.)
11. On November 3, 2016, NP O’Brien, who had taken over Patient AB’s care after Dr. Pham left, filed an incident report with the Family Health Center regarding Dr. Pham’s treatment of Patient AB. She stated that the patient’s lab results revealed stage 3b CKD, yet “[n]o notes [were] ever made in [the] medical chart of renal failure.” NP O’Brien stated that in spring 2016, the patient “stopped taking all medications and began a juicing regimen *instead*.”[[7]](#footnote-7) (emphasis added) (Pet. Ex. 2; O’Brien testimony - Tr. at 100-101.)

*Care of Patient AB’s Chronic Kidney Disease*

1. In March 26, 2014, Patient AB saw Dr. Sosa at the UMass renal clinic. She noted that his records showed that “he had never had any elevations of creatinine and his creatinines have always fluctuated from 0.7 to 1.08.” That day, however, the patient’s creatinine was 1.47 and his GFR was 50. Dr. Sosa discussed the patient’s diabetic neuropathy as part of her plan to treat his kidney disease. She told him that “the natural progression of diabetic neuropathy is to get worse with time” and that better management of his diabetes would forestall this progression. She therefore referred him to see an endocrinologist. Dr. Sosa advised him to follow-up with her once a year, “sooner if needed.” (Resp. Ex. 5 at 28 and 28a-d; Pet. Ex. 5.)
2. On May 22, 2014, during his first visit with Patient AB, Dr. Pham recommended supine knee exercises “to improve glucose control,” noted abnormal kidney function, and documented that the patient saw a nephrologist in January 2014. He ordered routine labs, including a test for creatinine. He noted that the patient was taking two diabetes medications (Glipizide and Metformin) and a blood pressure medication (Lisinopril). (Pet. Ex. 7.)
3. On July 20, 2014, Patient AB went to UMass for chest pain and shortness of breath. His creatinine was 1.75 and his GFR was 41, which were worse than shown in prior tests. Dr. Ira Ockene, a cardiologist, diagnosed Patient AB with bronchitis and stage 3b CKD (moderate to severe). He noted that given the downward trend of the patient’s kidney function tests, he “should be referred to a nephrologist on an out[patient] basis.” (Pet. Ex. 11.)
4. On September 12, 2014, Patient AB saw Nancy Sidhom, NP, at the UMass diabetes clinic. Ms. Sidhom noted “GFR is stable at 47…will keep an eye on that.”[[8]](#footnote-8) (Resp. Ex. 5 at 18.)
5. On September 29, 2014, Patient AB saw Dr. Pham. Dr. Pham’s plan was to repeat blood tests, incorporate dietary changes and supine knee exercises, and continue the patient’s medications. He was aware of Patient AB’s July visit to UMass for chest pain, and thought that his kidney function had declined because of this acute problem. He thus wanted to recheck the patient’s kidney function levels to see if an appointment with nephrology was warranted. (Pham testimony – Tr. at 291-292 ) The record does not reflect whether the patient followed up and had his blood drawn on this occasion. (Pet. Ex. 13.)
6. On January 22, 2015, Patient AB saw Dr. Pham and told him that he had not taken his medications in several days. Dr. Pham refilled all his medications, told the patient he needed to repeat his blood tests, and noted that he would follow up on the patient’s creatinine level. Other than a glucose blood test and an insulin injection strength test, the record does not reflect whether the patient followed through with the blood tests. (Pet. Ex. 14.)
7. Patient AB’s blood test results were next documented on March 25, 2015, when he saw Dr. Sosa at the renal clinic. He had a creatinine of 1.75 and a GFR of 41, indicating abnormal kidney function. Dr. Sosa stated that the patient’s CKD was “likely from diabetes,” which was poorly controlled. AB asked for a new referral to endocrinology as he had “lost to follow up and did not have a followup appointment.” Dr. Sosa “restarted [him] on [a] low dose of losartan and I encouraged him to continue.” She also provided him with an order to “recheck chemistry in a week to assure the potassium and kidney function remain in good range.” (Pet. Ex. 15; Resp. Ex. 5 at 25.)
8. On August 14, 2015, Patient AB saw Dr. Berry at the UMass urology clinic. Dr. Berry diagnosed him with chronic cystitis cystica, a “rare chronic reactive inflammatory disorder.”[[9]](#footnote-9) Dr. Berry noted that Patient AB “followed with Dr. Sosa.” (Pet. Ex. 20.)
9. Patient AB did not show up for his appointment at the UMass renal clinic on September 23, 2015. The clinic notified Dr. Pham of the no-show on September 30, 2015, and informed Dr. Pham that it had contacted Patient AB and advised him to contact the clinic if he wanted to reschedule. (Pet. Ex. 22.)
10. When a patient skips an appointment with a specialist, the patient’s treating physicians share the responsibility of checking on the patient and encouraging the patient to attend his or her next appointment. A doctor cannot compel a patient to show up for appointments or appear at laboratories for testing. (Angel testimony - Tr. at 353; Friedman testimony - Tr. at 722.)
11. On December 12, 2015, Patient AB went to the UMass emergency room after he woke up in the middle of the night, sweating, with shortness of breath and chest pain. He also had watery diarrhea for three days. His family reported that the patient “minimizes symptoms and will not report them” and that he continues to smoke. Patient AB’s creatinine was 2.09 and his GFR was 33, both indicative of worsening kidney function since March 2015. The hospital noted that he was noncompliant with follow-up and with medications. It evaluated him primarily for chest pain, and noted that he had acute kidney injury [“AKI”] as one of the patient’s nine diagnoses upon discharge, stating it was “likely pre-renal, from diarrhea,” and needed to be reassessed. (Pet. Ex. 24.) Dr. Angel agreed that the likely cause of the acute decline in Patient AB’s kidney function was the diarrhea he experienced. (Angel testimony – Tr. 387-388.)
12. On December 17, 2015, Patient AB followed with Dr. Pham after his hospitalization. He reported that he had been experiencing diarrhea 20 times daily and that, after leaving the hospital, he had moved in with his daughter. Dr. Pham requested that labs be performed to assess his kidney function. He discontinued two medications. (Pet. Ex. 25.)
13. On April 29, 2016, Patient AB made an office visit for back pain. He reported that he had lost weight and was feeling “more energized, appears younger with vegetable juices: kale, Broccoli, cucumber and lettuce.” Dr. Pham continued him on his medications, including his blood pressure medications. Patient AB’s blood pressure that day was 170/80. The doctor ordered blood tests. (Pet. Ex. 26.)
14. Patient AB last saw Dr. Pham on June 1, 2016 for an office visit following discharge from a hospital where he had been treated for pneumonia. The patient reported that he “does not take diabetes meds any longer. The sugar is very well controlled. He is taking a mixed juice of kale, celery, cucumber, broccoli as a cleanser.” Dr. Pham continued his current medications, including four medications for diabetes: acarbose, lantus, losartan, and novolog. (Pet. Ex. 28.)
15. Patient AB saw NP O’Brien on October 27, 2016. She filed an incident report regarding this visit because the patient told her that while he had been treating his diabetes and high blood pressure with medications, “he saw Dr. Pham in the spring of 2016 and stopped taking all medications and began a juicing regimen instead.” (Pet. Ex. 2.)
16. In Dr. Angel’s initial report to the Board based on his review of Dr. Pham’s medical records, he criticized the doctor’s treatment of Patient AB’s kidney disease because the doctor’s notes showed no plans for treatment of CKD and “there is no followup with a Nephrology consultant despite a history of renal disease.” (Pet. Ex. 1.) At the hearing, Dr. Angel repeated his position that Dr. Pham’s notes do not reflect a plan to treat Patient AB’s kidney disease. He also stated that “there’s no consistent, on-going awareness of kidney function, on-going demonstration of awareness of input from [an] outside consultant, like a nephrologist.” Angel testimony – Tr. 395-396.) He stated that the treatment of chronic kidney disease focuses first on treating underlying causes such as diabetes and high blood pressure, and that if medications prescribed to treat those conditions prove ineffective, a doctor should “consider getting a specialist involved.” (Angel testimony – Tr. 363-364.)
17. Dr. Friedman testified that Dr. Pham prescribed standard medications to treat Patient AB’s diabetes, hypertension, and chronic kidney disease, including Lisinopril, “which is commonly used in people with diabetes and early kidney disease to prevent progression.” He acknowledged that the patient’s creatinine levels were high, but stated that this was common in diabetics and not necessarily preventable.” (Freidman testimony – Tr. 637-641.)

**Patient AN**

1. Patient AN is a Vietnamese male in his mid-50s. He suffers from Hashimoto’s thyroiditis and epigastric pain/gastroesophageal reflux disease (“GERD”). (Pet. Ex. 32.)
2. Hashimoto’s thyroiditis is an “an autoimmune attack on the thyroid tissue,” causing an underactive thyroid. (Angel testimony - Tr. at 533.)
3. Thyroid-stimulating hormone (“TSH”) is made by the pituitary gland, which “tells your thyroid to make and release the thyroid hormones into your blood.” High TSH levels indicate hypothyroidism (an underactive thyroid) and low TSH levels indicate hyperthyroidism.[[10]](#footnote-10) (Angel testimony - Tr. at 397.)
4. The normal TSH range is 0.28-3.89 µIu/mL. Levothyroxine is a thyroid replacement hormone used to treat hypothyroidism. Patients on levothyroxine should have their TSH levels checked at least once per year. (Resp. Ex. 5 at 50; Angel testimony - Tr. at 397; Friedman testimony - Tr. at 645-646.)
5. The standard of care for the average primary care physician treating a patient with hypothyroidism is to gradually adjust the patient’s levothyroxine dose in response to the patient’s TSH levels. If the patient is seeing an endocrinologist, then the primary care physician is practicing within the standard of care if he adjusts the patient’s levothyroxine dose based on the endocrinologist’s notes and recommendations. (Friedman testimony – Tr. at 694-696.)
6. GERD is a condition in which “stomach acid frequently flows back into the tube connecting your mouth and stomach (esophagus).” The treatment of GERD can range from nothing to diet modifications to medications, depending on its severity.[[11]](#footnote-11) (Pet. Ex. 32.)
7. Dr. Pham addressed Patient AN’s GERD by advising him to avoid smoking and alcohol and prescribing omeprazole, a standard medication for GERD. (Pet. Exs. 33-34, 38, 40, 42-43.)
8. Between October 8, 2012 and July 1, 2016, Dr. Pham was Patient AN’s primary care physician at the Family Health Care Center. (Pet. Exs. 33-44.)

*Care of Patient AN’s Hypothyroidism*

1. Dr. John Mordes, an endocrinologist at UMass, had followed Patient AN for his Hashimoto’s thyroiditis since 2009. (Pet. Exs. 30-32.) On February 27, 2012, Patient AN told Dr. Mordes that he had run out of levothyroxine almost two months before the office visit. The patient “reported no symptoms suggestive of either hypo or hyperthyroidism since running out of medication.” Dr. Mordes noted that his last TSH reading was 0.64 in October 2011, which was a normal reading, but Dr. Mordes concluded that the patient was “probably biochemically hypothyroid at this time,” and therefore he decided to refill his levothyroxine at a dose of 150 mcg and order a new TSH test. By the time he wrote his office note on March 1, 2012, the TSH level was 12.48, indicating hypothyroidism. (Resp. Ex. 5 at 50; Pet. Ex. 30.)
2. On May 16, 2012, Dr. Mordes continued the levothyroxine dose at 150 mcg. He noted that treating Patient AN’s “hypothyroidism has proven to be a challenge due to difficulties with communications, refills, and his understanding of the need to take the medication in the correct way.” (Pet. Ex. 31.)
3. On August 29, 2012, Patient AN’s TSH was 0.06, indicating hyperthyroidism. Dr. Mordes decreased the patient’s levothyroxine dose to 137 mcg. (Pet. Ex. 32.)
4. On October 8, 2012, Dr. Pham saw Patient AN for the first time. His plan was to continue the patient’s levothyroxine. The dosage is not listed in the doctor’s notes. (Pet. Ex. 33.)
5. On April 4, 2013, Dr. Pham again saw Patient AN. Tirosint (levothyroxine) 50 mcg was listed under “Medications Active Prior to Today’s Visit.” He continued the patient’s levothyroxine. (Pet. Ex. 34.) He listed the dosage of levothyroxine at 50 mcg because that is the dosage the patient told him he was on. (Pham testimony – Tr. at 316.)
6. On April 11, 2013, Dr. Pham ordered a TSH test for Patient AN. His TSH was 0.26, indicating hyperthyroidism. His notes show the patient’s levothyroxine dose as 50 mcg. (Pet. Ex. 36; Resp. Ex. 5 at 53; Angel testimony - Tr. at 402-403.)
7. On April 29, 2014, Patient AN told Dr. Pham that he had not taken his thyroid medication for those months. The doctor examined his thyroid area and recorded that his “[n]eck is supple. Thyroid is symmetrical, without thyromegaly,[[12]](#footnote-12) masses or palpable nodules.” He ordered labs and increased the patient’s dose of levothyroxine to 125 mcg.[[13]](#footnote-13) On May 13, 2014, the lab report showed that patient’s TSH was 15.46, which indicated hypothyroidism. (Pet. Ex. 38 and 39; Resp. Ex. 5 at 55.)
8. Dr. Pham continued Patient AN on 125 mcg of levothyroxine at office visits on August 26, 2014, June 23, 2015, and October 15, 2015, June 8, 2016, and July 12, 2016. He ordered routine labs at the October 2015 visit. Each of these office visits were for stomach pain or hemorrhoids. There is no evidence that the patient followed through with the lab work. (Pet. Exs. 40-44.)
9. NP O’Brien reported that Patient AN’s TSH level was next checked in November 2016 and showed a TSH level of 30.44. His doctor upped his levothyroxine dose to 137 mcg. (Pet. Ex. 29.)
10. Dr. Angel’s initial report criticizes Dr. Pham’s medical records for not discussing thyroid function after 2014. (Pet. Ex. 108.) At the hearing, Dr. Angel opined that continuing to prescribe the same levothyroxine dose to Patient AN for two years without obtaining annual lab tests for TSH did not meet the standard of care. (Angel testimony – Tr. 406-407.) He agreed that, if a patient is not experiencing clinical thyroid symptoms, testing is not required. (Angel testimony – Tr. 500.)
11. Dr. Friedman testified that the drug Dr. Mordes prescribed, and Dr. Pham continued to prescribe, to Patient AN to treat his hypothyroidism was appropriate, and it was also appropriate for Dr. Pham to follow the dosage recommended by a specialist like Dr. Mordes. (Friedman testimony – Tr. 645-646 and 698-699.)

**Patient TT**

1. Patient TT is a male in his 50s and a long-time smoker who was a Vietnam veteran. Patient TT’s medical conditions include Hepatitis C, CKD, hypertension, and congestive heart failure. Dr. Pham was Patient TT’s primary care physician between 2011 and 2015. (Pham testimony - Tr. at 768; Pet. Exs. 46-74.)
2. Dr. Pham prescribed Patient TT hydrochlorothiazide, amlodipine, and Losartan to manage and treat the patient’s hypertension. All of these medications are standard treatments for hypertension. (Angel testimony - Tr. at 415, 508-509; Friedman testimony - Tr. at 660; Pet. Exs. 46-74.) Patient TT was non-compliant with his medications. (Angel testimony - Tr. at 537; Friedman testimony - Tr. at 656.)
3. Hepatitis C is a viral infection that mainly affects the liver and is usually blood-born. About half of people with Hepatitis C do not know they are infected because they will not have any symptoms, sometimes for decades.[[14]](#footnote-14) (Angel testimony - Tr. at 410.)
4. The first physician to diagnose a patient with Hepatitis C has a duty to disclose this diagnosis to the patient. Once a succeeding treating physician is aware of a patient’s Hepatitis C diagnosis, it is this physician’s responsibility to notify the patient of the diagnosis and make sure the patient understands the implications of the diagnosis. (Angel testimony - Tr. at 411-413.)
5. When caring for patient with chronic Hepatitis C, primary care physicians should monitor the patient for liver complications by conducting physical exams, blood tests, and ultrasounds. (Angel testimony - Tr. at 410.)
6. A patient’s viral load measures the presence of Hepatitis C in the blood. Checking a patient’s viral load, prior to starting treatment, is necessary to evaluate the severity of Hepatitis C and to monitor a patient’s progress while undergoing treatment. For patients with Hepatitis C who are *not* receiving treatment, checking viral load is unnecessary. (Angel testimony - Tr. at 410.)
7. Patients with both congestive heart failure and CKD are especially difficult to treat because the “treatment of one usually worsens the other.” Patients hospitalized for congestive heart failure tend to lose blood volume, which can cause an abnormal creatinine level during and shortly after hospitalization. (Friedman testimony - Tr. at 656, 661-662.)

*Care of Patient TT’s Hepatitis C*

1. On January 31, 2011, Patient TT made his first visit to Dr. Pham. The medical record for that day reflects that the patient had a “history of untreated hep C with viral loads in 2004 > 5 millions.” Dr. Pham learned this from Patient TT. (Pham testimony - Tr. at 767-768; Pet. Ex. 46.)
2. Patient TT told Dr. Pham that he did not want Hepatitis C treatment. Dr. Pham decided not to pursue the patient’s Hepatitis C treatment because the standard treatment at the time involved bi-weekly antipyrine injections that could lead to loss of appetite. anorexia, malaise, liver function decline, and worsen the patient’s existing depression. (Pham testimony - Tr. at 767-768.) This treatment process was complicated enough that it was generally undertaken by gastroenterologists who specialized in it, rather than by primary care physicians. (Friedman testimony - Tr. At 657.) Success of this treatment was largely dependent on a patient’s taking the prescribed medicine. (Angel testimony - Tr. At 536.)t
3. On January 21, 2015, Dr. Pham ordered blood tests for Patient TT. He had an elevated ALP (liver enzyme). A primary care physician, who has knowledge of a patient’s elevated liver enzymes when the patient has untreated Hepatitis C, should order imaging studies of the liver to assess for complications of Hepatitis C. (Pet. Ex. 57; Angel testimony - Tr. at 412.) On February 4, 2015, Dr. Pham re-checked Patient TT’s lab results. His ALP was normal. All of his liver enzymes were normal, according to the blood test results of January 5, 2016 and June 16, 2016. (Pet. Exs. 58-59.)
4. Patient TT began treating with NP O’Brien in 2017. She assumed he knew he had Hepatitis C because his medical records beginning in 2011 reflected this. But on March 29, 2017, he told her he did not know he had this disease. (O’Brien testimony - Tr. at 113 and 221; Bd. Ex. 45.)

*Care of Patient TT’s Chronic Kidney Disease*

1. On February 26, 2013, Dr. Pham ordered lab tests when the patient came in complaining of arm pain. The labs taken that day showed work Patient TT’s creatinine was 1.2, which is within the normal range. (Pet. Ex. 48 and 49.) Dr. Pham saw patient TT again on October 13, 2013. He ordered lab work. There is no record that the patient followed through; no lab results are in the medical record. (Pet. Ex. 50.)
2. In 2014, Patient TT visited Dr. Pham three times and was treated for bronchitis and chronic obstructive pulmonary disease. (Pet. Exs. 51-53)
3. On January 7, 2015, Dr. Pham saw Patient TT who came in complaining of shortness of breath. The patient looked ashen and his legs were swollen. Dr. Pham had an ambulance take him to the hospital. He thought the acute shortness of breath suggested lung, cardiac, and kidney problems, and that he may have pneumonia and acute renal failure. (Pet. Ex. 55.)
4. On the same day, Patient TT was admitted to the UMass cardiology unit for two nights. His creatinine was 1.58, which is elevated and his GFR was 43, which is low. Patient TT also had pulmonary edema, lower extremity swelling, and flu-like symptoms. The cardiologist prescribed Lasix, a diuretic, and instructed the patient to take it for his lower extremity swelling, as needed. A diuretic like Lasix can put stress on kidney function and make renal failure worse. The hospital listed acute renal failure as the fourth problem on Patient TT’s problem list, which listed malignant hypertension and acute diastolic heart failure as his chief problems. The doctor who wrote the note suspected that the cause of renal failure was hypoperfusion, i.e., decreased blood flow through his kidneys.[[15]](#footnote-15) (Pet. Ex. 55; Angel testimony - Tr. at 423.).)
5. In the following year and one-half, patient TT made numerous visits to Dr. Pham, and had lab work taken on many occasions. His lab results for creatinine were as follows: January 21, 2015, 2.0 (Pet. Ex. 57), February 4, 2015, 1.7 (Pet. Ex. 59), March 10, 2015, 1.7 (Pet. Ex. 61), January 5, 2016, 1.9 (Pet. Ex. 70), and June 16, 2016, 1.8 (Pet. Ex. 75.)
6. At a February 4, 2015 office visit, Dr. Pham noted that Patient TT’s creatinine level had increased to 2.0 while he was taking 40 milligrams per day of Lasix. He also listed, for the first time, acute renal failure as a problem to be addressed. He planned to repeat lab work and attempt to address the kidney issues by adjusting the patient’s blood pressure medications. (Pet. Ex. 58.) By the next visit on February 25, 2015, he noted that creatinine levels had dropped to 1.7 and appeared stabilized. He wrote in his notes that the most important treatment for the patient’s chronic kidney disease was a dietary change, by which he appears to have meant his effort to get the patient to cut down on the salt in his diet. (Pet. Ex. 60.) On March 10, 2015, the doctor again observed that creatinine had stabilized at 1.7 with a reduction in the Lasix dose to 20 milligrams per day. (Pet. Ex. 61.) Thereafter, he continued to monitor the patient’s salt intake. (Pet. Exs. 62-64 and 74.) In his office notes of Patient TT’s visit on January 12, 2016, he described the patient’s creatinine reading of 1.9 as “stable at baseline.” (Pet. Ex. 71.)
7. Treating a patient with kidney disease by controlling his blood pressure and restricting his salt intake is a standard practice. (Friedman testimony -Tr. at 661.)
8. If a patient experiences a sharp rise in creatinine after a recent hospitalization, the standard of care for an average primary care physician is to first review the patient’s medications and check whether the patient was not taking any of them. Dr. Angel thought that, after the January 5, 2015 labs showed the patient’s creatinine level had risen to 2.0, then “[m]aybe it’s time to have a kidney doctor take a look and consult.” (Angel Tr. at 421; Pet. Exs. 57-59.)
9. NP O’Brien submitted an incident report on March 29, 2017, in which she stated “Dr. Pham…prescribed diuretics despite CKD with a GFR in the 30s.” (Pet. Ex. 45.)
10. In his initial report, Dr. Angel criticized Dr. Pham for failure to address Patient TT’s acute renal failure. He did not specify otherwise what action or inaction of the doctor showed that he failed to address this problem. (Pet. Ex. 108.)

**Patient TN**

1. Patient TN was a widowed, Vietnamese female in her 70s. She suffered from CKD, tophaceous gout, malignant hypertension, spinal stenosis, and osteomyelitis. Patient TN was a non-compliant patient. She spoke only Vietnamese. (Pet. Exs. 78-103; Pham testimony -Tr. at 849; O’Brien Tr. at 217.)
2. While under Dr. Pham’s care, Patient TN was taking Toprol, Lisinopril, and Nifedipine, all medications used to treat hypertension.[[16]](#footnote-16) (Pet. Exs. 78-103.)
3. Tophaceous gout consists of tophi, “hard, uric acid deposits under the skin” that are typically found behind the ear, on the elbows, big toes, knees, and wrists.[[17]](#footnote-17) Unlike other types of gout, tophi themselves are not painful. (Friedman testimony -Tr. at 737.) The presence of tophi indicates a severe case of gout. (Angel testimony -Tr. at 438.)
4. A primary care physician should examine for gout if the patient reports a painful joint or new joint pains. A gouty joint may appear red and swollen and will be hot during an acute gout flare-up. If the patient exhibits these signs or reports symptoms, such as pain in the joint, the physician should check uric acid levels. Uric acid levels are not part of a routine blood test. (Angel testimony -Tr. at 435 and 437; Friedman testimony -Tr. at 729-730; Pham testimony -Tr. at 746.)
5. Allopurinol is a standard medication for treating gout. (Angel testimony -Tr. at 443.)
6. Osteomyelitis is a bone infection often resulting from the combination of vascular complications or a chronic, open wound that allows bacteria to get under the skin. (Friedman testimony -Tr. at 654.) Osteomyelitis is a distinct condition from gout, although it can be a “complication of advanced tophaceous gout.” (Angel testimony -Tr. at 440.)
7. From 2010 to 2015, Patient TN’s son was present at most of Patient TN’s appointments with Dr. Pham. In 2015, Patient TN’s daughter and her fiancé/husband started taking Patient TN to her appointments. (Pham testimony -Tr. at 745-747.)

*Care of Patient TN’s Chronic Kidney Disease*

1. On August 6, 2013, Patient TN saw Dr. Pham. Patient TN’s blood tests revealed low albumin, elevated liver enzymes, elevated BUN, and mildly elevated creatinine, all indicative of kidney dysfunction. (Pet. Exs. 78-79; Angel testimony -Tr. at 365, 367; Friedman testimony -Tr. at 650.) Dr. Pham’s records do not list a treatment plan for Patient TT’s kidney disease. His main focus was to lower her blood pressure, which was 200/100 when he began treating her. (Pham testimony -Tr. at 745.) Treating hypertension and monitoring a patient’s lab results is an appropriate method of treating chronic kidney disease. (Friedman testimony -Tr. at 650.)
2. For a primary care physician to meet the standard of care for treating a patient with kidney disease, he should re-check blood test results within one year for a patient with recent symptoms of kidney dysfunction. (Angel testimony -Tr. at 429-430.) There would be no need to repeat such tests if another institution performed them. (Freidman testimony – Tr. At 652.)
3. On August 20, 2014, Dr. Pham saw Patient TN, who had blood in her urine. He diagnosed her with a urinary tract infection and ordered a kidney ultrasound and blood tests. The blood tests taken on that date showed that Patient TN had elevated BUN, elevated creatinine, and a low GFR, all of which indicated kidney dysfunction. (Pet. Exs. 86-87.)
4. Between August 26, 2014 and March 24, 2015, Dr. Pham saw Patient TN five times. He did not order blood tests for Patient TN during this time. (Pet. Exs. 88-92; Resp. Ex. 5 at 62.)
5. In May 2015, a blood test performed at UMass showed that Patient TN’s BUN and creatinine were elevated. Her GFR was 39, which is abnormal. (Resp. Ex. 5 at 62.) UMass also performed blood tests on April 28, 2015, and October 8, 18, 20 and 22, 2015. (Resp. Ex. 5 at 63-73.)
6. On August 20, 2015, Dr. Pham saw Patient TN. The patient requested stronger pain medications and noted her difficulty obtaining transportation to appointments. (Pet. Ex. 96.)
7. On October 8, 2015, Dr. Howard Sachs, a hospitalist at UMass, listed “chronic kidney disease, stage III” as one of Patient TN’s diagnoses. Patient TN’s GFR was 45, which was abnormal, but improved since May 2015. (Pet. Ex. 97.) Chronic kidney disease, stage III is “moderately advanced kidney disease.” (Angel Ex. 108.)
8. On March 17, 2017, NP O’Brien filed an incident report regarding Dr. Pham’s treatment of Patient TN’s kidney disease. She reported that the patient had never been referred to a nephrologist. (Pet. Ex. 77). There are no records of Patient TN having been referred to a nephrologist. (Pet. Exs. 78-101; Resp. Ex. 5 at 60-82.)

*Care of Patient TN’s Gout/Rheumatological Condition*

1. In November 2012, Patient TN had left hip replacement surgery. (Pet. Ex. 78.)
2. On August 6, 2013, Dr. Pham saw Patient TN for right leg pain and right eye redness. Upon physical examination, Dr. Pham noted the patient’s irregular heart rhythm. He advised the patient to avoid frequent sitting. Dr. Pham prescribed Lidoderm patches, increased her Tylenol dosage, and ordered blood tests. (Pet. Ex. 78.)
3. Dr. Pham saw Patient TN on January 15, February 17, March 3, and March 24, 2015. She continued to experience pain in her right leg and hip. Dr. Pham ordered x-rays of the patient’s hips and lumbosacral spine, and referred her to an orthopedic surgeon for her hip. Dr. Pham administered acupuncture on two of those visits. This was the patient’s first acupuncture treatment. Dr. Pham did not mention gout in his notes. (Pet Exs. 89-92.) The patient did not tell the doctor that she was experiencing any gout symptoms, which is typically the way doctors learn of gout. Dr. Pham saw that she had swollen legs and that one of her toes had a pink discoloration and was swollen. He did not observe a draining ulcer in the vicinity of the toe. (Pham testimony - Tr. at 744 and 754.)
4. On April 28, 2015, Patient TN saw Nurse Practitioner Nicole Gibson at the UMass orthopedic clinic. She had been referred to the clinic by Dr. Metzmaker for evaluation of possible right fourth toe osteomyelitis. The patient told NP Gibson that she had “an open ulceration to her right fourth digit for approximately 6 months.” She also reported a history of gout. Ms. Gibson’s exam revealed a reddened toe with edema (swelling caused by excess fluid) and a pinpoint opening of “0.1 x 0.1” with sandy liquid drainage, without warmth or pain.[[18]](#footnote-18) The patient’s uric acid and C-reactive protein were elevated.[[19]](#footnote-19) Ms. Gibson advised the patient to return for a toe surgery consultation. (Resp. Ex. 5 at 63; Pet. Ex. 93.)
5. On May 5, 2015, Ms. Gibson diagnosed Patient TN with “right 4th distal and intermediate [toe] osteomyelitis” and tophaceous gout. Ms. Gibson explained the patient’s choices of taking antibiotics for up to eight weeks with wound care, or undergoing a toe resection.[[20]](#footnote-20) The patient chose the toe resection. (Pet. Ex. 94.)
6. On May 15, 2015, Dr. Lagana, a surgeon at UMass, amputated Patient TN’s toe, without any operative complications. Dr. Lagana confirmed that the toe had “extensive gouty infiltration.” He stated he would communicate with Dr. Pham about long-term gout treatment, and concluded that the patient’s prognosis was excellent. (Pet. Ex. 95.)
7. Dr. Lagana requested a pathology evaluation to determine whether the patient had osteomyelitis in her toe. There is no pathology report in the medical records. (Pet. Ex. 95.)
8. The expert witnesses disagreed on whether the toe amputation was necessitated by gout. Dr. Friedman opined that Patient TN lost her toe because the open wound led to osteomyelitis, a bone infection, which is a vascular issue “unrelated to gout.” (Freidman testimony -Tr. at 654.) Dr. Angel noted that osteomyelitis can be a complication of advanced tophaceous gout. He acknowledged that there were other possible causes of the skin breakdown, and that a definitive cause could not be determined without a pathology report, but it was his opinion that gout played a role in the patient’s skin breakdown. (Angel testimony -Tr. at 440 and 568.)
9. On August 20, 2015, Dr. Pham saw Patient TN for persistent right hip pain, which he believed was due to the asymmetry of the patient’s legs, as a result of the patient’s first hip surgery. The patient was awaiting a second hip surgery in October 2015. Dr. Pham’s notes mention that patient’s 4th toe on her right foot was removed because of osteomyelitis. His notes do not mention gout, but he added Allopurinol, a drug that treats gout, as a new medication. (Pet. Ex. 96.)
10. On October 19, 2015, Dr. Metzmaker performed a total right hip arthroplasty (hip replacement) on Patient TN. She had no serious surgical complications. (Pet. Exs. 97-98.)
11. On March 29, 2016, Dr. Pham saw Patient TN for a medication review, monitoring of gout, and a referral for removing a cyst on her wrist. The patient had a significantly improved ability to walk after her most recent hip replacement. Dr. Pham advised the patient to limit her salt and sugar intake and reduce the frequency of her allopurinol intake. He ordered lab tests and referred the patient for a surgical consultation for her cyst. (Pet. Ex. 101.)
12. NP O’Brien filed an incident report about Dr. Pham’s treatment of Patient TN’s gout after speaking to her son-in-law. The son-in-law told her that he had noticed a cyst on TN’s right wrist, and that she had subsequently been referred to a rheumatologist who diagnosed gout. Subsequently, the family disagreed with Dr. Pham about how to treat the gout. The son-in-law said the family objected to Dr. Pham’s non-standard treatment of gout, which relied primarily on turmeric, and reported that the doctor treated him and his wife (TN’s daughter) disrespectfully. (Pet. Ex. 77.)

*The Board’s Investigation of Dr. Pham*

1. The Board began its investigation of Dr. Pham in July 2017, one year after Dr. Pham left FHCW. The investigation was prompted by incident reports submitted with a July 20, 2017 letter from Interim Chief Medical Officer at the Family Health Center, Valerie Pietry, M.D., who had asked for an internal review of Dr. Pham’s treatment of patients based on concerns raised by providers who had taken over the care of Dr. Pham’s former patients. Dr. Pietry reported that the findings of that internal review showed that:

During approximately the last year of his practice with us, Dr. Pham appeared to turn to the use of herbal and dietary remedies as primary management of common chronic conditions, such as hypertension, arthritis and peptic ulcer disease, at times in lieu of standard evidence-based allopathic medical management approaches;

. . .

In a subset of patients, follow-up test results had lapsed, without apparent documentation from Dr. Pham as to the reasons, and patients were seen by other providers at the site to address outstanding findings, some of which were medically significant.

(Pet. Ex. 1.[[21]](#footnote-21)) The only Family Health Center practitioner mentioned in the record who raised questions about Dr. Pham’s treatment of his patients was NP O’Brien. (Pet. Exs. 1, 2, 29, 45, 77.)

1. The Board assigned Susan Dye to investigate Dr. Pham’s case. (Pet. Ex. 1.) As part of her investigation of Dr. Pham, Ms. Dye interviewed Dr. Pietry (CMO of FHCW), Dr. Rathmell (former Director of Integrative Medicine at FHCW), Dr. Byrne (former CMO at FHCW), NP O’Brien, and the son-in-law of patient TN. Ms. Dye also reviewed Dr. Pham’s FHCW employee records and incident reports, and retained Dr. Angel as an expert to review the medical records of Dr. Pham’s patients. (Pet. Ex. 1; Dye testimony -Tr. at 800-813.)
2. None of the four patients whose treatment is at issue complained about Dr. Pham. (Dye testimony - Tr. at 808-810.)
3. Prior to issuing Dr. Pham a summary suspension, Ms. Dye did not interview Dr. Culley or Dr. Pham. (Dye testimony - Tr. at 808-809.)
4. On November 22, 2017, the Board summarily suspended Dr. Pham’s license and issued a Statement of Allegations charging him with malpractice, gross malpractice, and misconduct in the practice of medicine. Inspector Dye’s affidavit, which was submitted in support of the motion, discusses the treatment of the four remaining patients whose care is the subject of the Statement of Allegations, and numerous other patients as well. An affidavit of the Board’s expert, Dr. Andrew Angel, was attached to Ms. Dye’s affidavit. Dr. Angel criticized Dr. Pham’s treatment of the four patients listed in the Statement of Allegations, and two others. He concluded:

[W]ith these examples taken individually and collectively, Dr. Pham’s medical care is severely lacking. His charting lacks detail and accuracy, and his medical judgment is often poor or nonexistent. For these reason he does not meet the standard of care for the practice of medicine. I would say he is an immediate danger to patients under his care.

(Pet. Ex. 1.)

**Discussion**

*Summary Suspension, Generally*

The Board of Registration in Medicine has the authority to license physicians to practice in Massachusetts, *see* M.G.L. c. 112, § 2 and 243 C.M.R. § 2.01(1), and to discipline a physician “upon proof satisfactory to a majority of the board that said physician . . . [is] guilty of conduct which places into question the physician's competence to practice medicine.” M.G.L. c. 112, § 5. The Board may suspend a physician’s license, if it shows that “a licensee is an immediate and serious threat to the public health, safety, or welfare.” 243 C.M.R. § 1.03(11)(a). A suspended physician is entitled to a prompt hearing. At the post-suspension adjudicatory hearing, the Board must prove by a preponderance of the evidence that the doctor is an immediate and serious threat to the public health, safety, or welfare. *See Randall v. Bd. of Registration in Medicine*, SJ-2014-0475, Memorandum of Decision (SJC, June 9, 2015); *Bd. of Registration in Medicine v. Shepard*, Docket No. RM-16-350, Decision (Mass. Div. of Admin. Law App., Oct. 14, 2016).

The Board may summarily suspend a physician’s license based on evidence of a “particular pattern of conduct on the part of the licensee.” *Bd. of Registration in Medicine v. Bock*, RM-14-16, Decision (Mass. Div. of Admin. Law App., Oct. 30, 2014; *adopted by Board*, Feb. 19, 2015) (physician’s repeated poor decision-making in course of treating patients was ground for summary suspension). Such conduct can include a “clear and consistent pattern” of negligent behavior. *Id.* (citing *Bd. of Registration in Medicine v. Rothchild*, Docket No. RM-08-27, Decision (Mass. Div. of Admin. Law App., Apr. 7, 2008; *adopted by Board*, July 16, 2013.) A physician is negligent when he or she “fail[s] to meet generally accepted standards of care within the medical community.” *Bd. of Registration in Medicine v. Osei-Tutu*, Docket no. RM-07-64, Decision (Mass. Div. of Admin. Law App., Jul. 8, 2008; *adopted by Board*, Feb. 25, 2009.)

The Board rarely has moved for summary suspension against doctors providing substandard care for patients with chronic diseases on a long-term basis. When it has disciplined physicians for substandard care of chronic diseases, the Board has applied a variety of sanctions that are milder than revocation. For instance, the Board reprimanded and fined an internist who failed to disclose a patient’s prostate antibody test results in a timely fashion, failed to re-check blood tests in a timely fashion, failed to adequately review the patient’s medical history, and failed to advocate for the patient to have an expedited biopsy of his prostate. *Matter of Osei-Tutu*, Adjudicatory Case No. 2007-004, Final Decision and Order (Bd. of Registration in Medicine, Feb. 25, 2009.)

*The Board did not meet its burden of proving by a preponderance of the evidence that Dr. Pham is a serious and immediate threat to the public health, safety, or welfare.*

1. Summary Suspension of a Physician who Does Not Practice in Massachusetts

The initial problem with the Board’s effort to summarily suspend Dr. Pham from practicing medicine in Massachusetts is that the doctor does not live or work here. The Board, as noted at the outset of this discussion, licenses and regulates only the practice of medicine in Massachusetts. While there is no doubt that it can discipline a doctor who holds a Massachusetts license but does not live or work here, it is a far different matter to demonstrate that a doctor who is not in the state presents “an immediate and serious threat to the public health, safety, or welfare” in Massachusetts.

Dr. Pham moved out of state in July 2016 to accompany his wife who had obtained a job in Maryland. He has been working as a physician in Maryland since September 2017. No evidence was presented at the hearing to show that there is any likelihood that the doctor will be moving back to Massachusetts in the near future. It might be possible, in some exceptional circumstance, to show that a doctor who does not live here is so likely to return to Massachusetts and disserve the patients in this state that he presents an immediate threat to the health of those residing here. However, the Board presented no evidence that this is true here.

1. Lack of Notice

Another serious problem with the Board’s case is the lack of notice to the doctor as to what the Board thought were the grounds to believe his patient care at the Family Health Center presented an immediate and serious threat to the public health, safety or welfare in Massachusetts.

The statute governing adjudicatory hearings in Massachusetts provides that:

Parties shall have sufficient notice of the issues involved to afford them reasonable opportunity to prepare and present evidence and argument. If the issues cannot be fully stated in advance of the hearing, they shall be fully stated as soon as practicable. In all cases of delayed statement, or where subsequent amendment of the issues is necessary, sufficient time shall be allowed after full statement or amendment to afford all parties reasonable opportunity to prepare and present evidence and argument respecting the issues.

M.G.L. c. 30A, § 11(1). Thus, in a summary suspension case, the Board has an obligation to inform the doctor by the time of the hearing, if not when it moved to suspend him, of the grounds on which it contends his continuing practice in Massachusetts would present an immediate threat to public health, safety or welfare.

The Board investigated Dr. Pham for three and one-half months before it filed its motion to summarily suspend him. During that time, its investigator, Ms. Dye interviewed a number of staff at the Family Health Center and its expert, Dr. Angel, reviewed records for six patients. Ms. Dye prepared a ten page single-spaced report of her findings, while Dr. Angel prepared a four page single-spaced critique of Dr. Pham’s patient treatment. These two documents are the only bases for the summary suspension motion. The one statement in either document that addresses the immediate threat to public health standard that such a motion must meet is the last line of Dr. Angel’s report, which reads “I would say he [Dr. Pham] is an immediate danger to patients under his care.” (Pet. Ex. 1.) The remainder of Dr. Angel’s report addressed instances in which he thought Dr. Pham’s patient treatment fell below the standard of care. But which of these critiques are the ones that Dr. Angel thought demonstrated that Dr. Pham’s care presented an immediate danger to his patients is not clear at all. This is simply insufficient notice.

It is not apparent why the Board could not have specified in its summary suspension motion the specific grounds it had for believing Dr. Pham’s patient care presented an immediate threat to his patients and to public health. Still, that deficiency could have been corrected at the hearing, either by counsel in his opening statement or by Dr. Angel in his testimony. The opening statement was short on such details, however. The closest it came to describing the bases for the motion was the following paragraph:

The issues relating to the four chronic disease management patients that are at issue only become apparent and manifest actually in the patients themselves after significant time has elapsed over appointment and appointments and appointments and months and months and sometimes years during which these chronic disease management patients, who oftentimes struggle with multiple chronic care conditions spanning from diabetes to hypertension to hyperkinemia to chronic kidney disease. In one patient, there is an issue of gout. The issues that manifest in these patients only become apparent and harm to them becomes apparent only after a period of time has elapsed such that their care for each of these conditions has been neglected that they are actually harmed.

(Tr. 43-44.) At best, what this suggests is that Dr. Pham’s overall care of the various chronic conditions each of the patients suffered was wholly inadequate to the point where each of them suffered some harm as a consequence. But what exactly the problems were with the care or what were the harms that the patients suffered that demonstrated an immediate threat remained unclear.

Dr. Angel’s testimony provided some detail as to the manner in which he thought Dr. Pham’s treatment of the four patients at issue deviated from the standard of care. However, the testimony did not make it clear to me what part of his critique addressed the issue of immediate harm. Therefore, at the close of his testimony, I asked him what he had meant in his initial report when he said that Dr. Pham presented and immediate threat to his patients. He replied:

His lack of evidence on his paper chart that he has a thought process about most of these issues. His notes are so vague and un-detailed that it’s unclear what registers with Dr. Pham as a serious medical problem and what he’s doing about it. And it’s just hard to imagine that this is a safe practice.

(Angel testimony – Tr. at 569.) This statement reflects a theme that otherwise runs though Dr. Angel’s critique of Dr. Pham, namely that his medical records were inadequate. Given these statements of the Board’s focus, it was not surprising that Dr. Pham attempted to defend himself by putting on evidence concerning his overall treatment of the various chronic diseases that afflicted his patients, and the issues he had with the computerized charting system used at the Family Health Center.

 In the introduction to his closing brief, Board counsel outlined much narrower areas of concern when specifying in what manner the Board believed Dr. Pham’s care failed to meet applicable standards. The Board now asserted that only certain of the chronic diseases that Dr. Pham treated were at issue. It maintained that for three of the patients Dr. Pham’s poor care led to their hospitalization, while the fourth patient need to have his medication adjusted as a consequence of Dr. Pham’s lack of care. The Board’s restatement of its positon was as follows:

As to Patient AB, The Respondent [Dr. Pham], over a period of approximately nineteen (19) months, failed to obtain and /or address the appropriate lab work to track kidney function and failed to appropriately refer Patient AB to a nephrologist, resulting in Patients AB’s admission to the UMass Memorial Medical Center (the “Emergency Department”) and diagnosis of acute kidney damage.

Conversely, the Petitioner’s [The Board’s] allegations against the Respondent relating to Patient AB do not relate to the Respondent’s approach to diabetes or hypertension.

As to Patient AN, the Respondent, over a period of approximately four (4) years, failed to obtain and/or address the appropriate lab work to track Patient AN’s hypothyroidism. While he neglected the crucial labs, the Respondent simultaneously lowered Patient AN’s thyroid medication such that the provider who treated Patient AN after the Respondent left the employ of the Family Health Center of Worcester (FHCW”) had to increase the dose of the medication.

Conversely, the Petitioner’s allegations against the Respondent relating to Patient AN do not relate to the patient’s alcohol and/or tobacco intake or gastro esophageal reflux disease.

As to Patient TN, the Respondent, over a period of approximately two (2) years, failed to obtain and/or address the appropriate lab work to track kidney function and failed to appropriately refer Patient TN to a nephrologist, resulting in Stage III Chronic Kidney Disease (“CKD”) and organ damage. Perhaps more alarming, the Respondent utterly neglected Patient TN’s gout over a similar period which resulted in amputation of one (1) of Patient TN’s toes and a portion of another one (1).

Conversely, the Petitioner’s allegations against the Respondent relating to Patient TN do not relate to hypertension, blood pressure, or lumbar spinal stenosis.

Finally, as to Patient TT, the Respondent, over a period of approximately two (2) years, failed to order and /or monitor the appropriate lab work to track kidney function and failed to appropriately refer Patient TT to a nephrologist, resulting in Patient TT’s admission to the Emergency Department and diagnosis with an acute renal failure. Perhaps more disconcerting, the Respondent never told Patient TT that he had Hepatitis C, causing Patient TT to unnecessarily endure that illness without treatment and, in turn, needlessly subjecting an untold number of people to same.

Conversely, the Petitioner’s allegations against the Respondent relating to Patient [TT] do not relate to hypertension or congestive heart failure.

While this post-hearing submission reflected some of the Board’s consistent concerns about Dr. Pham’s alleged failures to adequately monitor kidney disease and hypothyroidism, the Board added novel allegations that he represented an immediate threat to public health because his lack of care caused some of his patients to be hospitalized or have their medications changed. Only the charges that one patient had an amputation due to untreated gout and another patient was not treated for Hepatitis C had been raised previously. This post-hearing notice of the Board’s bases for the motion for summary suspension is wholly inadequate as it failed to give notice to the doctor of the charges he had to address at the hearing. It does not meet the notice standard set forth in Chapter 30A, let alone meet due process standards, and would be sufficient grounds to deny the motion. Nonetheless, because the parties have gone through a hearing, I will address the evidence that was presented.

1. Evidence Evaluation
2. *Dr. Pham’s Care of Patient AB*

In its motion for summary suspension, the Board alleged that Dr. Pham violated the standard of care in treating Patient AB’s diabetes, chronic kidney disease, and hypertension. However, after the hearing on the summary suspension, the Board no longer maintained its allegations relating to Dr. Pham’s approach to Patient AB’s diabetes or hypertension. Therefore, I will analyze only the Board’s allegation that Dr. Pham violated the standard of care as to Patient AB’s chronic kidney disease.

The Board’s post-hearing allegation is that Dr. Pham’s failure to obtain or address laboratory tests to monitor Patient AB’s kidney function and failure to refer Patient AB to a nephrologist accelerated harm to Patient AB as shown by UMass Hospital admission in 2015 and diagnosis with acute kidney injury.

I do not find any merit in the allegation that Dr. Pham failed to refer Patient AB to his nephrologist sooner than the nephrologist had recommended.

The medical records show that Patient AB saw Dr. Sosa, a nephrologist, in March 2014 just two months prior to seeing Dr. Pham for the first time. She provided a detailed plan for the patient’s CKD and stated that she advised the patient to follow up with her in one year, but sooner if needed. (Finding 31.) Dr. Pham documented this visit in the patient’s chart. The Board maintains that Dr. Pham should have sent patient AB back to Dr. Sosa sooner than March 2015 because, in July 2014, Patient AB went to the hospital complaining of chest pain and a cardiologist, Dr. Ockene, recommended that the patient be “referred to a nephrologist on an out[patient] basis.” (Finding 33.)

There is nothing in the record to reflect whether Dr. Ockene knew that Patient AB was already being treated by a nephrologist, nor is there anything in the record to show that this doctor thought that Patient AB’s kidney condition required immediate treatment by a nephrologist. All that can be said is that testing done at the hospital showed a decline in kidney function and that the doctor thought a nephrologist should be consulted. Patient AB did not see Dr. Pham again until September 2014. Dr. Pham’s testimony showed that he was aware by then of the July hospital visit and the decline in kidney function observed there. His testimony also showed that he thought that this decline was caused by the chest pains the patient was experiencing, and thus there was no need for an immediate referral to Dr. Sosa. (Finding 35.) There is no evidence in the record that would show that this was an unreasonable conclusion. Patient AB did see Dr. Sosa in March 2015. Her notes of that visit are routine, and do not include any criticism of Dr. Pham for failing to refer the patient to her sooner. (Finding 37.)

The alleged failure to refer Patient AB to a nephrologist sooner therefore does not show that Dr. Pham’s continued practice would be an immediate threat to public health.

The Board also alleged that Dr. Pham failed to monitor Patient AB’s kidney function tests for nineteen months. Contrary to these allegations, Dr. Pham saw Patient AB six times between 2014 and 2016 and ordered lab work on five of those six occasions. (Findings 32, 35, 36, and 42-43.) There is no evidence in the record that the patient complied with these directions or that the lab work orders were fulfilled. Indeed, there is ample evidence in the record that the patient was non-compliant in a variety of ways – failing to take his medications and failing to report symptoms among them. And, as Dr. Pham pointed out, labs could not be drawn at the satellite facility where he worked. (Finding 9.) Patients had to go to the main office or to UMass, and not all did. Nevertheless, labs were performed during this period for Patient AB when he went for treatment elsewhere, be it from Dr. Sosa, the UMass cardiologist, or a nurse practitioner. (Findings 33, 34, 37, and 41.) Neither Dr. Friedman nor Dr. Angel testified that the standard of care required Dr. Pham to instruct the patient to get his blood re-drawn just so that the results were based on his lab orders, rather than those of another physician.[[22]](#footnote-22)

The Board asserts that that Dr. Pham’s failure to monitor Patient AB’s kidney function led to his hospitalization in December 2015 with acute kidney failure. Were this proved, it would be the most likely basis for claiming that Dr. Pham’s treatment presented an immediate threat to public health. But there is no evidence for this whatsoever. The doctor who treated Patient AB in the hospital thought the acute kidney failure Patient AB experienced was likely related to the diarrhea he had experienced over the previous three days. So did Dr. Angel and Dr. Friedman. There is no evidence connecting Dr. Pham to this particular health crisis.

Finally, the Board notes that after Dr. Pham left the Family Health Center and Patient AB began treating with NP O’Brien, he told her that he had stopped taking his medications and instead was taking a juicing regimen. The Board evidently believes that this was Dr. Pham’s fault, presumably because the patient was acting on the doctor’s instructions. There is no evidence of this. Dr. Pham records reflect that the patient told him he had stopped taking his diabetes medications and was taking a juicing regimen, but there is no evidence that the doctor told him to stop taking his medications and consume juice instead. Indeed, his notes reflect that he continued to prescribe appropriate medications to the patient.

Although the Board insists that its motion is not based on Dr. Pham’s treatment of Patient AB’s diabetes and hypertension, his treatment of those diseases is still relevant to an evaluation of his treatment of Patient AB’s kidney disease. From the day he became Patient AB’s primary care physician until Dr. Pham left the Family Health Center, Dr. Pham appears to have properly managed the patient’s diabetes and hypertension. Both of these disorders are “precipitating factors” of CKD, and are, thus are relevant to evaluating whether Dr. Pham treated the patient’s kidney disease appropriately.

In sum, the evidence shows that Dr. Pham appropriately treated the underlying causes of Patient AB’s kidney disease, frequently sought to have a non-compliant patient submit to appropriate lab tests, did not fail to refer him to his treating nephrologist when appropriate, and did not cause the acute kidney failure that the patient experienced in December 2015. Thus, Dr. Pham’s care of Patient AB has not been shown to be a valid basis supporting summary suspension.

 b. *Dr. Pham’s Care of Patient AN*

 In its motion for summary suspension, the Board alleged that Dr. Pham violated the standard of care in treating Patient AN’s hypothyroidism, gastroesophageal reflux disease, and epigastric pain. However, after the hearing on the summary suspension, the Board no longer maintained its allegations relating to Dr. Pham’s approach to Patient AN’s gastroesophageal reflux disease and epigastric pain. Therefore, I will analyze only the Board’s allegation that Dr. Pham’s treatment of Patient AN’s hypothyroidism shows that summary suspension is justified.

The Board’s general allegation in the post-hearing brief is that Dr. Pham failed to monitor Patient AN’s TSH levels in the years he treated him and adjusted his thyroid medications without being informed by new TSH tests, and that a physician who subsequently treated the patient had to adjust the medication levels as a consequence. When discussing this patient in detail, the Board further honed the argument down to an assertion that on April 13, 2013 and April 29, 2014 Dr. Pham adjusted Patient AN’s levothyroxine dose without any basis and that, consequently, the dose had to be adjusted after Dr. Pham left the Family Health Center.

The Board did not prove these allegations. Dr. Pham ordered lab tests in 2013, 2014 and 2015; the patient appears to have gone for testing on two of these occasions. Therefore, the evidence does not show that, even if Dr. Pham prescribed in April 2013 or 2014 without recent lab tests, he prescribed without a basis. On April 13, 2013, he prescribed 50 mcg of levothyroxine. Dr. Pham testified that he believed he was simply continuing the patient at his current medication level. (Finding 60.) That was not the case: Dr. Mordes’s most recent prescription had been for 137 mcg. (Finding 58.) But that does not undermine the doctor’s testimony. When Patient AN first saw Dr. Pham on October 8, 2012, the doctor’s notes do not list the patient’s current dosage of levothyroxine, which suggests that he had not seen Dr. Mordes’s medical records. (*See* Finding 59.) The doctor still would have had a source of information as to what the current dosage was – the patient himself. It appears Patient AN half-remembered the dosage: he had been on 150 mcg for at least one year between 2012 and 2013; 50 mcg appears to have been a partial memory of that former dosage. While the Board doubts the doctor was truthful in testifying that he thought he was merely continuing the existing dosage, it had no ground for this doubt. It had not interviewed him before charging him, and was unaware of what his memory was of why he prescribed 50 mcg of levothyroxine. As a result, it lost an opportunity to investigate Dr. Pham’s recollection further.

Dr. Pham changed the levothyroxine dosage to 125 mcg in April 2014. (Finding 62.) The Board correctly notes that this change was made before lab results for Patient AN’s TSH level taken that day were available, which was not until two weeks later. (Finding 62.) But again, this does not show that the doctor lacked a basis for the change. The patient told the doctor that he had stopped taking his medication. The doctor then examined his thyroid, and adjusted his medication level. He ordered labs, but could not have based the prescription he wrote for Patient AN that day on the labs. He evidently made a decision based on the information he had that day, which was the patient’s history of thyroid problems, his statement that he had stopped taking his prescribed medication, and the information he gleaned from examining the patient. This seems not too dissimilar to what Dr. Mordes, the endocrinologist, did in February 2012 when the patient told him he had stopped taking his thyroid medication. The last lab results Dr. Mordes had showed the patient’s thyroid level to be normal. But given what he knew about Patient AN’s history, the doctor decided that, after the patient stopped taking his medication, he had probably become hypothyroid, and therefore prescribed him 150 mcg of levothyroxine. (Finding 56.)

Thus, Dr. Pham’s decision to change Patient AN’s medication levels was a judgment call based on the evidence he had available. While his judgment may be questioned, the Board’s position that the doctor acted arbitrarily without any judgment was not accurate. Furthermore, there is no evident basis for concluding that Dr. Pham’s judgment or actions put his patient’s health in immediate danger.

The Board also objects to the doctor continuing Patient AN on the same dose of levothyroxine for the next two years without obtaining further lab results, and notes that when Dr. Pham left the practice his next provider increased the dosage to 137 mcg. Dr. Pham saw Patient AN five times between April 2014 and July 2016. None of these visits was for a thyroid issue. The doctor had an opportunity to review the lab results that were reported in May 2014. He also ordered lab testing in October 2015, although it appears that the patient did not follow through. Even assuming that Dr. Angel is correct in recommending that TSH lab results for a thyroid patient be obtained annually, the record reflects that Dr. Pham attempted to obtain updated lab results, and there is no evidence that Patient AN was suffering any thyroid symptoms during this two year period on the dosage of medication Dr. Pham prescribed. Dr. Angel conceded that testing is unnecessary if the patient is not symptomatic. (Finding 65.)

That the patient’s dosage level was changed after Dr. Pham left the Family Health Center does not help the Board’s case. The next provider had new lab results to consider, and raised the levothyroxine dosage by 12mcg. This demonstrates only that levothyroxine dosing changed over time based on the evidence available to the treating physician, which is more than adequately shown by the changes during the course of Dr. Mordes’ s and Dr. Pham’s treatment of Patient AN. This last change hardly demonstrates that Dr. Pham’s care was inadequate, let alone that his care amounted to an immediate threat to public health.

 c. *Dr. Pham’s Care of Patient TT*

 In its motion for summary suspension, the Board alleged that Dr. Pham violated the standard of care by failing to address Patient TT’s hypertension, congestive heart failure, acute renal failure, and Hepatitis C. The Board also alleged that Dr. Pham failed to appropriately document various ailments and failed to make plans to treat these various ailments. In its closing brief, the Board modified its summary suspension allegations so they were limited to Dr. Pham’s monitoring and care of Patient TT’s Hepatitis C and chronic kidney disease.

*Care of Patient TT’s Hepatitis C*

The Board asserts that Dr. Pham behaved irresponsibly by failing to tell Patient TT that he had Hepatitis C, failing to discuss possible treatment with him, and failing to thereafter monitor his viral load. The reason the Board believes that Dr. Pham failed to tell the patient he had Hepatitis C is that, years later, the patient claimed to NP O’Brien that he was unaware of this diagnosis. The Board, having not interviewed Dr. Pham before the hearing, was unaware that the doctor recalled discussing the Hepatitis C diagnosis with the patient. (See Findings 74 and 75.)

There is no question that the Hepatitis C diagnosis predated Dr. Pham’s tenure as Patient TT’s primary care physician. The doctor noted this diagnosis in the notes of the patient’s first visit with him, although he had ordered no tests to determine whether the patient had this disease. The record suggests that Patient TT had been diagnosed by some other doctor years before. That being so, at least two doctors would have had an obligation to talk to Patient TT about the Hepatitis C diagnosis: the doctor who made the original diagnosis and Dr. Pham (and any other doctor who was his primary care physician in the intervening years). It is difficult to believe that neither the doctor who made the diagnosis nor Dr. Pham told the patient he had hepatitis C. It is far more likely that Patient TT had lived for years with untreated, asymptomatic Hepatitis C and had pushed it out of his mind by 2017 when he spoke with Nurse O’Brien. On the other hand, it is also likely that in 2011, when he met Dr. Pham, Patient TT was the source by which the doctor learned of the Hepatitis C diagnosis, as he said he did. There is no information in the record that the doctor had any prior medical records of Patient C, let alone records of whoever the doctor was who made the diagnosis (or whether that diagnosis was made in the United States or in Vietnam). Thus, Patient TT was the most likely source of source of information, and therefore Dr. Pham can hardly be credibly accused of keeping him in the dark as to the diagnosis.

Once Dr. Pham knew of the diagnosis, he had an obligation to discuss possible treatment with Patient TT. Dr. Pham testified that he did so at his first meeting with the patient. The medical record does not reflect this, and the doctor can be criticized for failing to document a conversation in which he said the patient declined treatment for Hepatitis C, but that is not sufficient to demonstrate that he presents an immediate danger to the public health. Moreover, I believe he had this conversation. The factors he mentioned are ones that could sensibly have led a doctor at the time to believe treatment was not warranted. The treatment at the time required frequent injections and had possibly serious physical and mental side effects that might deter doctors -- particularly when treating a patient who was historically non-compliant with medications – from recommending that the patient go through with the complex treatment process. (Finding 75.) It would also be unsurprising that a patient like TT, who had lived with this disease for years without any symptoms, would see no compelling reason to go through with a difficult treatment process. Thus, it is also unsurprising that Patient TT declined treatment.

As for the Board’s criticism of Dr. Pham for failing to subsequently check Patient TT’s viral load, it has not shown that he thereby demonstrated that his practice would be an immediate threat to the public health. Dr. Angel, the Board’s own expert, refuted the assertion that Dr. Pham should have been routinely checking Patient TT”s viral load by testifying that such checking was not necessary if the patient was not undergoing treatment for Hepatitis C. (Finding 72.)

 *Care of Patient TT’s Chronic Kidney Disease*

 The Board’s case that Dr. Pham’s treatment of Patient TT”s chronic kidney disease shows that he is an immediate threat to public health suffers, more than any of its other claims, from lack of notice to the doctor of exactly what the allegations are. Prior to the hearing, the allegations were vague charges related to unspecified problems with his treatment of the patient’s acute kidney failure. At the hearing, Dr. Angel testified about Dr. Pham’s treatment of the patient following his hospital admission in 2015 for heart problems and associated kidney failure. However, Board counsel questioned Dr. Pham only about this treatment of the patient before he was hospitalized. Having not asked the doctor why he took the steps he did post-hospitalization, the Board’s closing brief focused heavily on criticisms of the patient’s post-hospitalization treatment. Needless to say, without a clear idea of what the Board was charging, the doctor was left without proper notice as to which of his actions he needed to defend.

In any event, the Board failed to prove that Dr. Pham’s treatment of this patient's kidney problems demonstrates that his continued practice presents an immediate threat to the public health. The Board, in its closing brief, argues that over a two year period pre-hospitalization, Dr. Pham failed to request order labs to monitor Patient TT’s kidney function, leading to his admission to the hospital with kidney failure in 2015. The evidence does not support these charges. First, there is no evidence in the medical record that the patient suffered from kidney disease when he saw Dr. Pham in February 2013. His lab tests for creatinine taken at the time were normal. (Finding 78.) Thus, there was no apparent reason for the doctor to request follow-up labs focusing on kidney function. Second, there is no evidence that any failure to monitor Patient TT’s kidney function led to a kidney failure that caused him to have to be admitted to the hospital. Rather, the evidence is that Patient TT was admitted to the hospital in 2015 with heart problems, was treated in the cardiology unit, and developed kidney failure as a result of his heart problems. This was the opinion of both the hospital and Dr. Friedman. (Findings 73 and 81.) Dr. Angel was not asked to offer an opinion on this question. The cause of the patient’s kidney failure was a matter beyond common knowledge and could only be established through expert opinion. Thus, the Board’s asertion that Dr. Pham’s treatment led to Patient TT’s hospitalization is unsupported.

As for the doctor’s treatment of the patient following his hospitalization, the Board maintains that it is befuddled by what Dr. Pham was doing and contends that he should have ordered labs more frequently and sent the patient to be examined by a nephrologist. Because the doctor was not asked at the hearing to explain his treatment of the patient during this period, he was not given an opportunity to defend himself from these particular charges. This is wholly unfair to the doctor, and it would not be proper to use the evidence related to these charges as a basis to summarily suspend him, even if the evidence proved the charges. But it does not. The medical records show that the doctor had developed an approach to Patient TT’s kidney problems, which lingered on post-hospitalization. He sought to monitor the blood pressure medications that the patient was receiving and get him to modify his diet to limit salt intake. (Finding 83.) Dr. Pham recognized that the diuretic Lasix that the hospital had prescribed to reduce the patient’s blood pressure put pressure on his kidney function, and thus he reduced the prescription amount. (Finding 83.) He also continued to question the patient about his salt consumption. Dr. Friedman testified that controlling blood pressure and reducing salt intake are standard treatments for kidney disease. (Finding 84.) The combination of the failure to question the doctor about the criticisms the Board had of his approach and the failure to recognize and address the plan the doctor had for treating Patient TT’s kidney problems amount to a lack of proof that his care of the patient’s kidney problems demonstrates the he represents an immediate threat to public health.[[23]](#footnote-23)

 d. *Dr. Pham’s Care of Patient TN*

 In its motion for summary suspension, the Board alleged that Dr. Pham violated the standard of care regarding management and treatment of Patient TN’s chronic kidney disease, hypertension, and gout. Now, the Board is retaining only its allegations regarding the patient’s chronic kidney disease and gout. However, while that was its assertion in the introduction to its closing brief, it did not follow up with any detailed explanation of its positon on the kidney disease treatment.

 *Care of Patient TT’s Kidney Disease*

Because the Board has never explained in any detail why it thinks that Dr. Pham’s treatment of Patient TT”s kidney disease shows that he presents an immediate threat to public health, I will not address this unexplained charge at length. The apparent gist of it is that the doctor’s alleged inattention to the patient’s chronic kidney disease led it to become chronic kidney disease, stage III. The trouble with this allegation is that there is no evidence to suggest that the disease had recently deteriorated to this level when Dr. Sachs described it this way in October 2015. (*See* Finding 101.) It could just as well have been stage III chronic kidney disease throughout Dr. Pham’s treatment of Patient TN. Indeed, when Dr. Sachs saw Patient TN, one of her lab tests showed a better result than the previous one, suggesting that her condition had improved. (Finding 101.) And the Board’s expert, Dr. Angel, did not treat this as a crisis diagnosis, describing State III kidney disease as “moderately advanced.” (Finding 101.)

 *Care of Patient TN’s Gout*

The Board alleges that Dr. Pham failed to treat Patient TN for gout, which led to her losing a toe to the disease, and that this poor treatment demonstrates that he is an immediate threat to the public health. There is no dispute that Dr. Pham did not diagnose or treat Patient TN for gout before she had a gouty toe amputated. But whether this demonstrates such poor medical practice that the doctor’s continued practice would present an immediate threat to the public health turns on whether he should have diagnosed gout prior to the amputation.

The Board has not shown this. The typical way a doctor learns that a patient has gout is when the patient suffers a painful attack of gout or suffers new joint pains and reports these problems to her doctor. (Finding 91.) There is no evidence that the patient reported gout symptoms to Dr. Pham in the various visits she had with him in the months preceding her toe amputation.[[24]](#footnote-24) She does not appear to have been suffering from painful gout symptoms even at the time of the amputation. She did not report any pain to NP Gibson, who saw her a few days before the amputation and found that her toe was not warm, which it likely would have been were she suffering from an attack of gout. (Finding 106.) Doctor Pham did observe that her toe had a pink discoloration and it and her legs were swollen (Finding 105), but there is no testimony that this observation, in the absence of any complaints of pain in the toe, should have led him to diagnose gout and fell so far below standard medical practice to show that his practice presents an immediate threat to public health. That the orthopedist to whom Dr. Pham referred Patient TN for hip issues diagnosed gout does not of itself demonstrate that Dr. Pham’s care was poor. We do not know what Patient TN told this doctor or whether she developed toe symptoms that she had not described to Dr. Pham.

The Board also alleges that Dr. Pham missed the draining wound adjacent to the toe that became infected and that was the immediate cause of the toe amputation. Dr. Pham testified that he did not observe any draining wound on Patient TN’s feet. (Finding 105.) The Board’s basis for its contention that this demonstrates a treatment failure on his part is its belief that the wound had been draining for six months. But the only evidence of such a long-existing open wound is NP Gibson’s note of her conversation with Patient TN. (Finding 106.) But there is no evidence as to how good an historian this patient was. Thus, there is no solid evidence as to how long this skin break existed or how long it was draining. All that is known is that by the time Patient TN saw NP Gibson, the open wound was tiny. It was described by NP Gibson as a “pinpoint opening.” (Finding 106.) There is no evidence as to the condition of this area during any of the four visits when Dr. Pham saw Patient TN in the six months preceding her visit with NP Gibson. (*See* Finding 105.) Was such a small wound in existence for the whole time and draining throughout this period? Was it more recent or draining only on and off? These questions cannot be answered from the record. All that can be said is that Dr. Pham did not see a draining wound during any of these four visits. Without knowing whether a draining wound was present at any of these visits, I cannot determine whether his treatment of the patient fell below acceptable medical practice, let alone that it was so deficient as to demonstrate that his continued practice represents an immediate threat to public health.

**Conclusion**

For the reasons stated above, I conclude that the Board has not shown by a preponderance of the evidence that Dr. Pham’s treatment of any of the four patients at issue was so poor as to demonstrate that any continued practice he might undertake in Massachusetts would present an immediate and serious threat to the public health, safety, or welfare. I therefore recommend that the motion for summary suspension be denied.

 DIVISION OF ADMINISTRATIVE LAW APPEALS

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 James P. Rooney

 First Administrative Magistrate

Dated: September 6, 2019

1. The motion also cites 243 CMR 1.03(11)(b), which allows the Board to summarily suspend a doctor’s license if he “may be a serious threat to the public health,” and indeed, in its second paragraph stated that the affidavit of its inspector “demonstrates that Dr. Pham represents a serious threat to the public health, safety or welfare.” Board counsel, however, avers that the Board was pursing only the assertion that Dr. Pham’s continued practice presents an immediate and serious threat to the public health. [↑](#footnote-ref-1)
2. The Board’s first exhibit is an affidavit of its investigator, Susan Dye. The affidavit originally included a series of attached exhibits. The Board did not include those when it filed its hearing exhibits. The letter that prompted the Board’s investigation was Exhibit 1 to Ms. Dye’s affidavit. I have added it to the Board’s hearing Exhibit 1. I have also added another exhibit that was originally attached to Ms. Dye’s affidavit, namely the report of the Board’s expert, Dr. Andrew Angel. [↑](#footnote-ref-2)
3. References are to the three volume transcript of the hearing. [↑](#footnote-ref-3)
4. On February 25, 2015, Dr. Culley received an e-mail from Steven Malchman, the director of medical records and compliance officer at the Family Health Center. In the e-mail, Mr. Malchman reported that a patient of Dr. Pham’s had various complaints and requested a different provider. One of the complaints was that Dr. Pham criticized the patient’s weight. Dr. Culley did not remember receiving this e-mail. Once Board counsel showed him a copy of the email, he opined that the complaint was common to medical providers and that doctors routinely tell diabetes patients to lose weight and are criticized for this advice.

The Board, in its closing brief, observes that the email mentions more serious concerns, such as the patient complaining of knee pain, which Dr. Pham attributed to her weight and, in doing so, failed to notice that she had two torn meniscus, a ligament tear, a sprained ACL and bone fragments. Dr. Culley was not asked about this, but he stated that this patient’s problems seemed to stem from osteoarthritis. From this, counsel contends that Dr. Culley’s “method of complaint review involved defensiveness and unfounded assumptions about a patient’s history and care.” I do not find this conclusion warranted. Dr. Culley’s testimony about the method the Family Health Care Center used to evaluate its doctors routinely and his own efforts to review Dr. Pham’s work hardly suggest that he was lax in his concern for patient care. And since he was not questioned about his opinion that this patient's knee problems are likely attributable to arthritis, there is no evidence that his conclusion on that score is unwarranted. (*See* Culley testimony - Tr. at 607-609; Pet. Ex. 105.) [↑](#footnote-ref-4)
5. <https://www.mayoclinic.org/tests-procedures/creatinine-test/about/pac-20384646>. [↑](#footnote-ref-5)
6. <https://www.niddk.nih.gov/health-information/professionals/clinical-tools-patient-education-outreach/explain-kidney-test-results>. [↑](#footnote-ref-6)
7. The second statement is what Patient AB allegedly told Ms. O’Brien. [↑](#footnote-ref-7)
8. Ms. Sidhom’s note does not indicate when Patient AB had his blood drawn. There are no records in evidence of any blood lab results between July 20, 2014 and March 25, 2015. [↑](#footnote-ref-8)
9. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5369394/>. [↑](#footnote-ref-9)
10. <https://www.webmd.com/women/what-is-tsh-test#1>. [↑](#footnote-ref-10)
11. <https://www.mayoclinic.org/diseases-conditions/gerd/symptoms-causes/syc-20361940>. [↑](#footnote-ref-11)
12. Thyromegaly, also known as goiter, is a “disorder in which the thyroid gland . . . becomes abnormally enlarged.” <https://www.healthline.com/health/thyromegaly>. [↑](#footnote-ref-12)
13. In his “Assessment/Plan,” Dr. Pham confusingly wrote “resume prior dose of levothyroxine 112 mcg,” a dosage Patient AN had not been on. Yet, under the patient’s medication list, levothyroxine was shown as 125 mcg, and subsequent visits listed the same dosage. (Pet. Exs. 38 and 39.) Therefore, the 112 mcg reference seems simply to be an error in creating the medical record, rather than a reflection of a dosage the doctor actually prescribed. [↑](#footnote-ref-13)
14. <https://www.mayoclinic.org/diseases-conditions/hepatitis-c/symptoms-causes/syc-20354278>. [↑](#footnote-ref-14)
15. *See* https://www.merriam-webster.com/medical/hypoperfusion. [↑](#footnote-ref-15)
16. Toprol is a type of beta-blocker and lowers heart rate, blood pressure, and strain on the heart. <https://www.webmd.com/drugs/2/drug-9548/toprol-xl-oral/details>. Nifedipine is a type of calcium-channel blocker that relaxes the blood vessels, which increases circulation. <https://medlineplus.gov/druginfo/meds/a684028.html>. [↑](#footnote-ref-16)
17. <https://www.hopkinsarthritis.org/arthritis-info/gout/clinical-presentation-of-gout/>. [↑](#footnote-ref-17)
18. NP Gibson did not state what length measure “0.1” referred to. Assuming she was measuring in centimeters, the discharge area would have been one millimeter by one millimeter, which could accurately be referred to as a pinpoint discharge. [↑](#footnote-ref-18)
19. C-reactive protein is a marker of inflammation. A high CRP value indicates “serious infection, trauma or chronic disease, which likely will require further testing to determine the cause.” <https://www.mayoclinic.org/tests-procedures/c-reactive-protein-test/about/pac-20385228>. [↑](#footnote-ref-19)
20. Ms. Gibson utilized a Vietnamese interpreter to explain these choices. (Pet. Ex. 94.) [↑](#footnote-ref-20)
21. Dr. Pietry’s letter is now part of the Board’s Exhibit 1. [↑](#footnote-ref-21)
22. The Board argues that Dr. Pham failed to follow up on a directive Dr. Sosa gave him during Patient AB’s visit with her to have the patient’s blood rechecked in one week. The medical record does not support this. Dr. Sosa’s notes reflect that she “provided [Patient AB] with an order to recheck chemistry in a week to assure the potassium and kidney function remain in good range.” (Finding 37.) That is, her directive was to the patient, not to Dr. Pham. [↑](#footnote-ref-22)
23. The proof the Board offered was not particularly strong, in any event. For example, Dr. Angel opined only that under the circumstances presented, “[m]aybe it’s time to have a kidney doctor take a look and consult.” (Finding 85.) [↑](#footnote-ref-23)
24. The only part of the record that suggests the doctor was told that Patient TN had gout was NP O’Brien’s report of her conversation with TN’s son-in-law. This report is so inconsistent with the medical record as to be useless. The son-in-law reported that he discovered that TN had gout by noticing a cyst on her hand, and thereafter the family had arguments with Dr. Pham because he insisted on treating her with a non-standard regimen. (Finding 114.) The record reflects however that the cyst on the hand was discovered after Patient TN’s toe was amputated and that Dr. Pham was not treating the patient for gout before the amputation, but was treating her thereafter with a standard gout medication. (Findings 111 and 113.) I can therefore draw no reliable conclusions from this report. [↑](#footnote-ref-24)