COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2013-052

In the Matter of

MARC F. FREEDMAN, M.D.

STATEMENT OF ALLEGATIONS

The Board of Registration in Medicine (Board) has determined that good cause exists to believe the following acts occurred and constitute a violation for which a licensee may be sanctioned by the Board. The Board therefore alleges that Marc F. Freedman, M.D. (Respondent) has practiced medicine in violation of law, regulations, or good and accepted medical practice, as set forth herein. The investigative docket number associated with this order to show cause is Docket No. 11-322.

Biographical Information

1. Respondent was born on January 23, 1958. He graduated from the University of South Florida College of Medicine in 1984. He is certified by the American Board of Obstetrics and Gynecology. He has been licensed to practice medicine in Massachusetts under certificate number 71001 since 1989. He does not have privileges at any Massachusetts hospital.

Factual Allegations

2. At all times relevant to the allegations contained herein, the Respondent had privileges at Winchester Hospital ("Winchester").

3. On June 16, 2011, pursuant to G.L. c. 111, § 53B, Winchester reported to the Board that the Respondent voluntarily agreed not to exercise his clinical privileges at Winchester, pending a clinical and personal assessment by the Physician Assessment and Clinical Education Program at the University of California Santa Barbara ("PACE").

4. The Winchester action was based upon two adverse outcomes in surgical cases performed by the Respondent, specifically matters involving his substandard performance of periurethral lacerations on Patient A and Patient B.

5. On January 23, 2012, the Respondent's medical privileges and appointment to the medical staff at Winchester lapsed and he submitted an application for gynecology privileges only. Winchester denied his application.

Patient A

6. Patient A, a female, was born in 1982.

7. Patient A was admitted to Winchester on February 17, 2011 at 9:07 p.m. to the Labor and Delivery Unit (L&D) at 39 weeks gestation with suspected ruptured membranes.

8. The Respondent was not Patient A's obstetrician; he provided coverage to Patient A's obstetrician who was paged to report to the hospital.

9. The Respondent completed a Physician Admit History & Physical at 9:58 p.m. on February 17, 2011.

10. The Respondent wrote that Patient A was Gravida1, Para0, with an estimated date of confinement of February 24, 2011.

11. At 6:32 a.m., the Respondent documented that Patient A was in "normal progression of labor."

12. The Respondent performed a vaginal delivery of Patient A's child at 7:04 a.m. on February 18, 2011.

13. Patient A sustained a periurethral second degree laceration during the delivery.

14. Post-delivery, at 7:55 a.m., Patient A's lochia flow was heavy; Patient A was also tachycardiac with a heart rate of 127.

15. At 8:00 a.m., a nurse documented observing clots, and called Patient A's obstetrician to the patient's room.

16. Patient A continued to experience heavy vaginal bleeding, which did not abate with administration of medications.

17. Patient A's obstetrician performed a vaginal examination on Patient A, and observed a suture which tied two labia minora in the midline, leaving a very small opening in the vagina.

18. Patient A's obstetrician inserted a finger in Patient A's vagina, whereupon approximately 1000 ml of blood clots were extracted; the obstetrician also detected a left vaginal tear which appeared to extend high toward to the left fornix.

19. The obstetrician removed the suture and confirmed the presence of an extensive vaginal tear of the left lateral wall of the vagina.

20. The obstetrician took Patient A to the operating room and also observed large amounts of blood clots.

21. Intra-operatively, the obstetrician found that Patient A's extensive vaginal tear extended to the fornix on the left side, with visualization of a blood vessel that was pumping blood steadily though the upper part of the laceration.

22. The obstetrician repaired the vaginal tear, and also noted the presence of a smaller tear on the upper part of the labia minor that was split in two locations; the obstetrician repaired those tears, as well as a superficial periurethral tear on the right side.

23. An post-repair ultrasound confirmed no further bleeding or clots.

24. Patient A experienced an estimated 2300 ml of blood loss as a result of these various tears.

25. The Respondent deviated from the standard of care in that he failed to accurately document Patient A's medical record.

26. The Respondent deviated from the standard of care in that he failed to recognize the vaginal laceration.

27. The Respondent markedly deviated from the standard of care when he sewed the labia minor together in a completely aberrant fashion.

Patient B

28. Patient B is a female, born in 1997.

29. The Respondent was not Patient B's obstetrician; he provided care to Patient B at Winchester, in the obstetrician's absence.

30. Patient B's estimated date of confinement was May 13, 2011.

31. Patient B saw her obstetrician on May 16, 2011 for a routine office visit; at that time, Patient B's cervix was 4-5 cm. dilated, and 90% effaced.

32. Patient B's obstetrician's plan was to induce Patient B.

33. Patient B was admitted to Winchester's L&D on May 16, 2011 for NST testing.

34. Around 6:00 p.m., Patient B became uncomfortable; an epidural was administered.

35. At 6:27 p.m., Patient B, at 5 cm. dilated, spontaneously ruptured her membranes and precipitously delivered a 9-pound, 9-ounce female; a Winchester Laborist attended the delivery.

36. Patient B sustained a small periurethral tear.

37. The Respondent repaired that tear.

38. A surgeon physician took Patient B to the operating room to complete the surgery under anesthesia.

39. During an attempt to insert a foley catheter, the surgeon discovered that Patient B's urethral opening was sewn closed by the Respondent.

40. The Respondent had closed off Patient B's urethral meatus when he repaired the right periurethral laceration.

41. The surgeon removed the Respondent's sutures to re-open the urethral meatus, and discovered extensive damage to Patient B's cervix, which included a long laceration at 7 o'clock which extended into the lower uterine segment, and a second 2 cm. laceration at 12 o'clock.

42. The surgeon repaired both cervical lacerations, as well as the right periurethral laceration.

43. The Respondent deviated from the standard of care in that he failed to accurately document Patient B's delivery.

44. The Respondent deviated from the standard of care in that he failed to recognize that he sewed the urethra closed.

45. The Respondent deviated from the standard of care in that he abandoned Patient B without any explanation, and did not participate or otherwise assist others in Patient B's post-delivery surgery.

Patient C

46. Patient C is a female, born in 1963.

47. Patient C had a history of heavy menses, with golf ball-sized clots lasting for days.

48. In an operative note at Winchester dated June 3, 2010, the Respondent noted that Patient C was Gravida2, Para2.

49. Patient C also complained of fatigue and the need to wear feminine pads that had to be changed two and three times per day during time of heavy flow.

50. Patient C's symptoms had been worsening in the months leading up to the June 3, 2010 procedure.

51. Patient C's pre-operative ultrasound showed multiple fibroids, with one measuring 4 x 3.6 cm., another measuring 2 x 2.6 cm., and a third measuring 2.5 x 2.3 cm.

52. The Respondent's pre-operative impression was menorrhagia and leiomyoma of the uterus.

53. The Respondent planned to perform a laparoscopic assisted vaginal hysterectomy, possible total hysterectomy, or possible bilateral salpingo-oopherectomy.

54. Under laparoscopic visualization, the Respondent observed several large fibroids; he decided to perform an abdominal hysterectomy.

55. The Respondent documented his intraoperative findings as enlarged and irregular uterus, secondary to leiomyomata of the uterus, with normal appearing ovaries and tubes.

56. The Respondent's operative notes state that he removed the uterus and the cervix, closed the vaginal cuff, and irrigated the pelvis with sterile water; no bleeding was observed, and good hemostasis was noted.

57. While in the Winchester PACU, Patient C was noted to have minimal output of bloody urine; a different physician ordered an urgent cystogram.

58. The cystogram identified a single clot which was evacuated at the initiation of the procedure, then a normal 225 ml. bladder without any extravasation.

59. Patient C was discharged to home on June 5, 2010.

60. On June 10, 2010, at 4:00 a.m., Patient C awoke with hematuria and severe right lower quadrant pain. She suddenly developed lightheadedness, could not keep her eyes open, and was seeing stars.

61. Patient C was taken to the Winchester ER; she was admitted with dysuria, bladder spasms and non-specific abdominal pain.

62. On June 11, 2010, a urologist evaluated Patient C.

63. The urologist's assessment was possible bladder injury, or a suture in the bladder that could have been missed on the cystogram.

64. Patient C was discharged from Winchester, with instructions to follow up with a urologist for a further cystogram.

65. On June 14, 2010, Patient C underwent a further cystogram procedure, which identified a vicryl suture through the bladder wall with some puckering of the bladder mucosa around it, posterolateral to the right urethral orifice, with no sign of active bleeding.

66. A vicryl suture is dissolvable, thus the urologist did not remove it during the cystogram.

67. The Respondent deviated from the standard of care when, in performing an open total abdominal hysterectomy, he failed to remove the entire cervix.

68. The Respondent deviated from the standard of care by inserting a suture into the bladder.

69. The Respondent deviated from the standard of care in that he failed to document a note when Patient C was readmitted to Winchester on June 10, 2010.

Legal Basis for Proposed Relief

A. Pursuant to G.L. c. 112, §5, ninth par. (c) and 243 CMR 1.03(5)(a)3, the Board may discipline a physician upon proof satisfactory to a majority of the Board, that he engaged in conduct that places into question the Respondent's competence to practice medicine, including but not limited to gross misconduct in the practice of medicine, or practicing medicine fraudulently, or beyond its authorized scope, or with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions.

B. Pursuant to 243 CMR 1.03(5)(a)17, the Board may discipline a physician upon proof satisfactory to a majority of the Board, that said physician has committed malpractice within the meaning of M.G.L. c. 112, § 61.

C. Pursuant to *Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1979); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708 (1982), the Board may discipline a physician upon proof satisfactory to a majority of the Board, that said physician has engaged in conduct that undermines the public confidence in the integrity of the medical profession.

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

Nature of Relief Sought

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

Order

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

By the Board of Registration in Medicine,

Gerald B. Healy

Gerald B. Healy, M.D.
Board Vice-Chair

Date: October 23, 2013

SENT CERTIFIED MAIL 10/24/13 mg