COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2018-0602

In the Matter of	)
KEVIN R. LOUGHLIN, M.D.	)

CONSENT ORDER

Pursuant to G.L. c. 30A, § 10, Kevin R. Loughlin, M.D. (Respondent) and the Board of Registration in Medicine (Board) (hereinafter referred to jointly as the "Parties") agree that the Board may issue this Consent Order to resolve the above-captioned adjudicatory proceeding. The Parties further agree that this Consent Order will have all the force and effect of a Final Decision within the meaning of 801 CMR 1.01(11)(d). The Respondent admits to the findings of fact specified below and agrees that the Board may make the conclusions of law and impose the sanctions set forth below in resolution of investigative Docket No. 15-161.

Findings of Fact

1. The Respondent was born in August 1949. He graduated from New York Medical College in 1975 and is certified by the American Board of Urology. The Respondent has been licensed to practice medicine in Massachusetts under certificate number 51081 since June 1983.

2. The Respondent practiced at Brigham and Women's Hospital ("BWH") and Harvard University Health Services ("HUHS") from 1983 to 2015.

Patient A:

3. In June 2014 Patient A went to HUHS for a consult with the Respondent after learning that his Prostate-specific Antigen ("PSA") level was elevated.

4. The Respondent recommended that Patient A have a prostate biopsy to determine whether he had prostate cancer.

5. On July 7, 2014, the Respondent performed the biopsy at BWH.

6. On July 14, 2014, Patient A's biopsy results were completed and recorded in his BWH medical record.

7. The Respondent had a personal notebook in which he kept a log of his patients' test results and his attempts to notify them of the same.

8. The Respondent erroneously put a check mark next to Patient A's name in his personal notebook.

9. The Respondent believed, based on the check mark next to Patient A's name, that he had notified Patient A of the positive biopsy results.

10. On May 22, 2015, Patient A went to HUHS for a visit with his primary care provider ("PCP").

11. Patient A's PCP informed him of the positive biopsy results from July 2014.

12. Patient A's PSA level on May 22, 2015 was essentially unchanged from July 2014.

13. The Respondent's failure to notify Patient A of his positive biopsy results in a timely manner constituted negligence.

Patient B:

14. In January 2014 Patient B was referred to the Respondent for an evaluation of a symptomatic non-obstructing left renal stone (kidney stone).

15. On May 6, 2014, Patient B saw the Respondent for evaluation of left flank pain.

16. On May 9, 2014, Patient B underwent a renal ultrasound.

17. On May 27, 2014, the Respondent reviewed the results of Patient B's renal ultrasound which showed mild fullness of the left kidney as well as the presence of two left renal stones.

18. From June to July 2014 Patient B repeatedly contacted HUHS requesting the results of his ultrasound.

19. At some point between July 21, 2014 and October 2, 2014, the Respondent informed Patient B that his ultrasound was normal.

20. The Respondent did not record in Patient B's medical record that he notified Patient B of the ultrasound results.

21. On October 2, 2014, Patient B went to his PCP at HUHS complaining of continuing left flank pain.

22. On October 2, 2014, Patient B's PCP informed him that the May 9, 2014 renal ultrasound actually revealed the presence of two 6mm renal stones.

23. Patient B subsequently had a Computerized Tomography ("CT") scan of his left kidney performed. The scan revealed hydronephrosis (swelling of the kidney) and the presence of small stones in the left ureter.

24. On December 8, 2014, Patient B underwent dilation of a ureteral stricture (narrowing of the ureter) which was performed by another urologist at BWH.

25. The Respondent's failure to provide Patient B with an accurate description of his ultrasound results constituted negligence.

26. The Respondent's failure to provide Patient B with his ultrasound results in a timely manner constituted negligence.

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.

Conclusion of Law

A. The Respondent has violated G.L. c. 112, §5 (c) and 243 CMR 1.03(5)(a)3 by engaging in conduct which calls into question the physician's competence to practice medicine, including, but not limited to, negligence on repeated occasions.

Sanction and Order

The Respondent is hereby reprimanded. A permanent license restriction is imposed pursuant to M.G.L. c. 112, s. 5A and 243 C.M.R. 1.05(7), that prohibits the Respondent from the clinical practice of medicine.

Execution of this Consent Order

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

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

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

The Respondent shall provide a complete copy of this Consent Order with all exhibits and attachments within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which he practices medicine; any in- or out-of-state health maintenance organization with whom the Respondent has privileges or any other kind of association; any state agency, in- or out-of-state, with which the Respondent has a provider contract; any in- or out-of-state medical employer, whether or not the Respondent practices medicine there; the state licensing boards of all states in which the Respondent has any kind of license to practice medicine; the Drug Enforcement Administration Boston Diversion Group; and the Massachusetts Department of Public Health Drug Control Program. The Respondent shall also provide this notification to any such designated entities with which the Respondent becomes associated for the duration of the practice restriction. The Respondent is further directed to certify to the Board within ten (10) days that the Respondent has complied with this directive.

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

Kevin R. Loughlin, M.D.
Licensee

11/26/18
Date

William J. Dailey, Jr., Esq.
Attorney for the Licensee

11/26/18
Date

Lisa L. Fuccione
Complaint Counsel

12-10-18
Date

So ORDERED by the Board of Registration in Medicine this 20th day of December 2018.

Candace Lapidus Sloane, M.D.
Board Chair