

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2018-064

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| In the Matter of |) |
| Ankur M. Parikh, M.D. |) |

CONSENT ORDER

Pursuant to G.L. c. 30A, § 10, Ankur M. Parikh, M.D. (Respondent) and the Board of Registration in Medicine (Board) (hereinafter referred to jointly as the "Parties") agree that the Board may issue this Consent Order to resolve the above-captioned adjudicatory proceeding. The Parties further agree that this Consent Order will have all the force and effect of a Final Decision within the meaning of 801 CMR 1.01(11)(d). The Respondent admits to the findings of fact specified below and agrees that the Board may make the conclusions of law and impose the sanction set forth below in resolution of Investigative Docket No. 16-287.

Biographical Information

1. Respondent was born in August 1981. He graduated from Temple University School of Medicine in 2007. He is certified by the American Board of Urology. He has been licensed to practice medicine in Massachusetts under certificate number 251385 since 2012. He holds privileges at Saint Vincent Hospital, UMass Memorial Medical Center (UMMC) and Marlborough Hospital.

Findings of Fact

2. During the afternoon of July 12, 2016, Respondent had an initial consultation scheduled with Patient A, a sixty-five year old male suffering from gross hematuria (presence of blood in the urine). Patient A appeared as an "add on" to Respondent's schedule that morning. As a result, Respondent did not review Patient A's referral and records at the start of the day.

3. At the outset of the consultation Respondent asked Patient A if he had a Computerized Axial Tomography (CT) scan performed. Patient A responded in the affirmative and informed Respondent that he had a CT scan performed at UMMC on July 8, 2016.

4. The Respondent subsequently logged into the UMMC medical records system and attempted to access the CT scan of Patient A's bladder, kidneys and ureters by entering in Patient A's first and last name. The Respondent did not ask Patient A to provide a second identifier such as a date of birth.

5. The Respondent's medical record query yielded a copy of a CT scan performed on another individual who has the same first and last name as Patient A. This other individual had the exact same CT scan of the abdomen and pelvis performed on the same day as Patient A at UMMC. That individual's CT scan revealed the presence of a large kidney tumor, which Respondent assessed as consistent with the clinical finding of gross hematuria.

6. Based on his review of the wrong CT scan Respondent incorrectly informed Patient A that he had a large tumor on his left kidney and would need to undergo a radical nephrectomy (removal of a kidney). The Respondent scheduled the surgery to be performed on July 20, 2016 at Saint Vincent Hospital.

7. On July 15, 2016, Respondent saw Patient A at his office a second time. During this visit he conducted a cystoscopy to rule out the presence of any bladder tumors. The result of

that procedure revealed that Patient A had a small bladder tumor. The Respondent advised Patient A of this information and informed him that he would remove the bladder tumor immediately before he removed the left kidney.

8. At various times between the initial office visit on July 12, 2016 and the evening before surgery on July 19, 2016, Respondent logged into the UMMC medical records system to view Patient A's CT scan. However, Respondent accessed the scan by using a tool that allows users to access images they recently viewed without reentering the patient identifiers. As a result, Respondent continuously reviewed the wrong CT scan.

9. On July 20, 2016, Respondent attempted to log into UMMC's medical records system from a computer at Saint Vincent Hospital. However, he was unable to log in due to problems with a recently installed firewall that prevented access to UMMC's system. Respondent elected to proceed with the surgery without reviewing Patient A's CT scan.

10. Prior to removing Patient A's left kidney Respondent noted that that the kidney did not feel particularly heavy. Despite his observations Respondent did not stop and attempt to review Patient A's CT scan.

11. After removing Patient A's left kidney Respondent received a call from the pathologist who indicated that there was no tumor present. Respondent went to the pathology lab and confirmed the absence of a large tumor.

12. Respondent's surgical assistant subsequently logged into UMMC's medical records system on his personal laptop computer. At that time, the surgical assistant noted that there were two individuals with the same name who had CT scans performed at UMMC on July 8, 2016. The Respondent looked at the CT scans, realized that he had diagnosed and operated on

Patient A based on his analysis of the wrong CT scan, and informed the patient what had happened.

13. Respondent's treatment of Patient A fell below the standard of care at three distinct points: 1) at the initial visit when Respondent failed to use multiple patient identifiers to retrieve the correct CT scan; 2) on the morning of surgery when Respondent elected to begin the procedure without looking at the CT scan; and 3) during the second phase of the surgery when Respondent elected to continue removing the kidney after observing that the left kidney did not feel as heavy as one would expect given the size of the tumor.

14. Patient A suffered harm as a result of having his left kidney removed.

Conclusion of Law

A. The Respondent has violated G.L. c. 112, § 5, eighth par. (h) and 243 CMR 1.03(5)(a)17 by committing malpractice within the meaning of G.L. c. 112, § 61.

B. The Respondent has violated G.L. c. 112, § 5, eighth par. (c) and 243 CMR 1.03(5)(a)3 by engaging in multiple acts of negligence.

Sanction and Order

The Respondent's license is hereby reprimanded.


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

Execution of this Consent Order

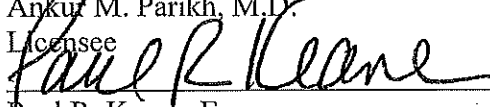
The Respondent shall provide a complete copy of this Consent with all exhibits and attachments within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which he practices medicine; any in- or

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 he becomes associated in the year following the date of imposition of this Reprimand. 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.



Ankur M. Parikh, M.D.
Licensee



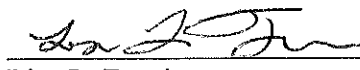
Paul R. Keane, Esq.
Attorney for the Licensee

8/26/18

Date

9/10/18

Date

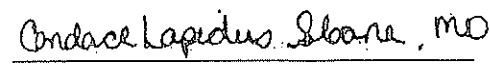


Lisa L. Fuccione
Complaint Counsel

9/11/18

Date

So ORDERED by the Board of Registration in Medicine this 20 day of Dec,
2018.



Candace Lapidus Sloane, M.D.
Board Chair