

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2018-663

In the Matter of

HOOSHANG D. POOR, M.D.

CONSENT ORDER

Pursuant to G.L. c. 30A, § 10, Hooshang D. Poor, 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. 15-030.

Findings of Fact

1. The Respondent was born on March 5, 1950. He graduated from the University of Pahlavi Faculty of Medicine in 1977. His practice specialty is Internal Medicine and Geriatrics. He has been licensed to practice medicine in Massachusetts under certificate number 50091 since 1982. He sees his patients at their nursing homes. He is affiliated with New England Baptist Hospital.

Patient A

2. Patient A is 61 year-old man who was treated at a hospital for a gastrointestinal bleed after surgical anastomosis and thereafter admitted to a skilled nursing facility on December 3, 2012, where he was under the care of the Respondent. Patient A had a number of conditions including congestive heart failure, chronic atrial fibrillation, end-stage renal disease from nephrosclerosis, hypertension, mild diabetes, and clostridium difficile colitis.

3. In Patient A's admitting note at the skilled nursing facility, the Respondent continued hospital discharge orders for oxycodone as needed and Risperdal at bedtime.

4. In Patient A's admitting note, the Respondent provides an inadequate evaluation of Patient A's symptoms. While the Respondent's note states that Patient A has no shortness of breath, the Respondent fails to comment on whether Patient A experiences shortness of breath on exertion, chest pain, dizziness, or orthostatic symptoms.

5. Patient A had a diagnosis of dementia and was taking Risperdal, however, beyond the notation of "well oriented," the Respondent's notes fail to show that the Respondent performed a mental status examination.

6. The Respondent's care of Patient A failed to meet the standard of care by failing to document:

- i. in his notes the reason for continuing the hospital's discharge orders for Oxycodone PRN and Risperdal at bedtime
- ii. an adequate evaluation of Patient A's symptoms;
- iii. that he performed a mental status exam beyond "well oriented" of Patient A, who was a certified level II PASRR recipient with longstanding stable developmental disability with a guardian for medical decision making.

Patient B

7. The Respondent provided care to Patient B, who was a 62 year old woman admitted to a skilled nursing facility following a diagnosis of chronic atrial fibrillation, congestive heart failure, ischemic heart disease, chronic obstructive lung disease, peripheral arterial disease, drug dependency, anxiety, depression, and degenerative disc disease, which resulted in radiculopathy and chronic pain.

8. The Respondent's notes for Patient B did not reflect a thorough examination of Patient B, a complete medical history, and inadequate assessment of her congestive heart failure.

9. While Patient B had a diagnosis of chronic obstructive lung disease prior to her admission to the skilled nursing facility, the Respondent did not perform pulmonary function testing or determine oxygen saturation levels on exertion. The Respondent's determination of whether there was adequate control of Patient B's condition with the medications she was taking was not adequately reflected in his records.

10. The Respondent's care of Patient B failed to meet the standard of care by:

- i. Failing to document a complete examination of Patient B, note a complete medical history, and adequately assess her congestive heart failure; and
- ii. Failing to perform pulmonary function testing or oxygen saturation levels on Patient B to determine whether her condition was stable on medication.

Patient C

11. Patient C was a 40 year old woman at a skilled nursing facility when her care was transferred from another physician to the Respondent on September 28, 2012.

12. Patient C suffered from hypertension, gastro esophageal reflux disease, anxiety, posttraumatic stress disorder, and bronchospasm.

13. Patient C underwent hemipelvectomy and laminectomy surgery with placement of a spinal rod from the ilium on Lumbar 3 on March 21, 2011. After the procedure Patient C suffered chronic low back pain.

14. The Respondent ordered a nursing assessment of the patient's pain every shift.

15. However, while Patient C was also being treated at a pain clinic and the Respondent's notes of Patient C's pain state that it "seems controlled," these notes did not characterize the pain by (a) radiation, (b) intermittent or constant, (c) factors that exacerbate the pain, (d) factors that relieve the pain, or (e) the intensity of the pain.

16. The Respondent's care of Patient C failed to meet the standard of care by failing to adequately document his personal assessment of Patient C's pain.

Patient D

17. Patient D was a 59 year-old woman in a skilled nursing facility, who by 2012 was under the care of the Respondent.

18. Patient D suffered from diabetes, coronary artery disease, congestive heart failure, chronic kidney disease, schizophrenia, hypothyroidism, and had limb and metatarsal amputations.

19. While the Respondent's notes for Patient D for November 27, 2012 include a complaint of fresh blood in her stool, these symptoms were attributed to a diagnosis of hemorrhoids without his notes providing adequate history to support the diagnosis. For example, the Respondent's notes do not address prior colonoscopy, family colon cancer history, or whether an anoscope or colonoscopy were indicated.

20. Patient D had transfers to an acute care hospital for various treatments during her stay at the skilled nursing facility, including an admission to the hospital from April 3, 2013 to April 9, 2013, with cardiorespiratory arrest and acute renal failure with hyperkalemia.

21. Medical notes for Patient D on April 11, 2013 indicate complaints of chest discomfort with no indication that the Respondent pursued this complaint.

22. Patient D had history of hypertension, congestive heart failure, and renal failure and was hospitalized for dehydration and pre renal azotemia. While staff records contain notes documenting the patient's weights, vital signs and labs, the Respondent had few personal notes which documented Patient D's vital signs, including weight gain, which would have tracked whether these health problems were being controlled.

23. The Respondent's care of Patient D failed to meet the standard of care by:

- i. Failing to adequately assess and diagnose the fresh blood in Patient D's stool and failing to order diagnostic testing,
- ii. Failing to document Patient D's vital signs on a regular basis to address her hypertension and renal failure, and
- iii. Failing to document Patient D's weight on a regular basis in light of her significant weight changes and health concerns.
- iv. Failing to document whether and how he addressed Patient D's chest discomfort.

24. The Respondent's medical notations for Patient A through D were at times illegible and thus, below the standard of care.

Conclusion of Law

A. The Respondent has violated G.L. c. 112, § 5, eighth par. (c) and 243 CMR 1.03(5)(a)3 by engaging in conduct that places into question the Respondent's competence to practice medicine including practicing medicine with negligence on repeated occasions.

B. The Respondent has violated G.L. c. 112, § 5, eighth par. (h) and 243 CMR 1.03(5)(a)11 by violating a regulation of the Board—to wit:

1. 243 CMR 2.07(13)(a), which requires a physician to maintain a medical record for each patient, which is adequate to enable any other health care provider to provide proper diagnosis and treatment.

Sanction and Order

The Respondent's license is hereby SUSPENDED indefinitely. The Respondent is GRANTED leave to petition for a stay of the suspension immediately. Any stay will be conditioned upon the Respondent's entry into a standard five-year Probation Agreement that includes the following:

- a) A Practice Audit by a Board-approved entity, to be completed within ninety days of the execution of the Probation Agreement, involving a review of the Respondent's documentation and billing of 25 randomly selected patient records;
- b) Compliance with any and all of the auditor's recommendations; and

Any other terms and conditions that the Board deems appropriate. This sanction is imposed for each violation of law listed in the Conclusion section and not a combination of any or all of them.

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.

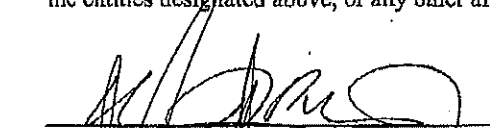

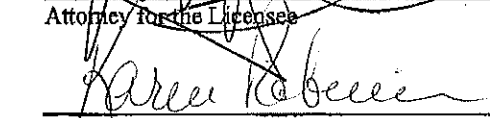
As to any matter in this Consent Order left to the discretion of the Board, neither the Respondent, nor anyone acting on his behalf, has received any promises or representations regarding the same.

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 and Probation Agreement, 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 this

stayed suspension and probation agreement. 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.

 _____ Licensee	<u>12/18/17</u> Date
 _____ Attorney for the Licensee	<u>12/19/17</u> Date
 _____ Complaint Counsel	<u>12/19/17</u> Date

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

Candace Lapidus Sloane, MD
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Board Chair