COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

MIDDLESEX, SS

Adjudicatory Case No. 2018-021
(RM-18-0350)

In the Matter of

Emily G. Strehle, D.O.

FINAL DECISION AND ORDER

Procedural History

On May 25, 2018, the Board of Registration in Medicine issued a Statement of Allegations (SOA) against Emily G. Strehle, D.O. (Respondent) and referred the matter to the Division of Administrative Law Appeals (DALA) for Findings of Fact and Conclusions of Law.

DALA Magistrate Bonney Cashin (Magistrate) held a pre-hearing conference on August 7, 2018 and held a hearing on July 6-8, 2021. In her July 16, 2024 Recommended Decision, which is attached hereto and incorporated by reference, the Magistrate found that the Respondent's experts' testimony was more reliable than that of the Board's expert with respect to the standards of care. The Magistrate also found the patient's testimony was less reliable than that of the Respondent with respect to the events in dispute.

Neither party filed Objections to the Recommended Decision. On July 24, 2024, the Respondent filed "Request for Disposition of Respondent, Emily Strehle, D.O." requesting that the Board dismiss the charges and exonerate the Respondent.

Discussion

Where a Magistrate's Findings of Fact rest upon a resolution of credibility questions, the Magistrate is entitled to substantial deference. See *Vinal v. Contributory Retirement Appeal Board*, 13 Mass.App.Ct. 85, 101 (1982). The Board cannot reject a Magistrate's determination of credibility absent a clear and articulable reason for such a rejection. See *Morris v. Board of*

Registration in Medicine, 405 Mass 103, 111 (1989). Having been afforded substantial deference in making credibility determinations, it is incumbent upon the Magistrate to provide thorough and reasoned explanations for her decision to credit or discredit testimony. See *Herridge v. Board of Registration in Medicine*, 420 Mass 154, 156 (1995).

In the current matter, the Magistrate provided clear and detailed reasons for each of her credibility findings and identified the portions of testimony that were relevant to her ultimate Conclusions of Law.

After full consideration of the Magistrate's Recommended Decision, the Board hereby dismisses the Statement of Allegations on the basis that the Board did not sustain its burden of proving its charges against the Respondent and, in accordance with M.G.L. c. 112, § 5, exonerates the Respondent.

Date: September 12, 2024

Booker T. Bush, M.D., Chair
Board of Registration in Medicine

COMMONWEALTH OF MASSACHUSETTS

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

Board of Registration in Medicine,
Petitioner

v.

Emily G. Strehle, D.O.
Respondent

Docket No. RM-18-0350

Appearance for Petitioner:

Tracy Morong, Esq.[1]
Board of Registration in Medicine
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Appearance for Respondent:

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Administrative Magistrate:

Bonney Cashin

Summary of Recommended Decision

The Respondent met the standard of care. She did not commit malpractice, practice medicine deceitfully, or engage in conduct that has the capacity to deceive or defraud; nor did she engage in conduct that undermines the public confidence in the integrity of the medical profession.

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[1] Stephen C. Hoctor, Esq., who is now retired, served as Complaint Counsel past the closing of the record.

RECOMMENDED DECISION

Introduction

On May 25, 2018, the Board of Registration in Medicine ("Board") issued a Statement of Allegations ordering Emily G. Strehle, D.O., to show cause why she should not be disciplined by the Board for practicing medicine in violation of law, regulations, or good and accepted medical practice. The Board alleged that Dr. Strehle committed misconduct, gross misconduct, negligence, gross negligence, and malpractice; practiced medicine deceitfully or engaged in conduct that has the capacity to deceive or defraud; and engaged in conduct that undermines the public confidence in the integrity of the medical profession. On May 24, 2018, the Board referred the matter to the Division of Administrative Law Appeals ("DALA"). On July 23, 2018, Dr. Strehle filed an answer to the Board's Statement of Allegations with six affirmative defenses.

A lengthy discovery period followed the pre-hearing conference on August 7, 2018, and continued into 2020. By then, DALA ceased holding live hearing because of the COVID pandemic.

As time passed, Dr. Strehle agreed to a hearing using the Webex platform. I conducted the hearing on July 6-8, 2021. The Board offered three witnesses, including Dr. Strehle, who called three witnesses on her behalf. I admitted five exhibits.

Following the Board's expert's testimony, Dr. Strehle moved for summary decision. (Tr. I: 175-182.)[2] I heard additional argument the following day and converted the motion to a motion to dismiss. (Tr. II: 4-25.) After noting that the motion was likely premature, I took it under advisement. 801 CMR 1.01(7)(g)1. The motion is denied. I determined that I could not decide the entire case without hearing additional evidence.

[2] References to the transcripts are Tr. Vol. No.: pg. no. The transcript volumes' pages were not consecutively numbered. Where the testimony was repetitious, I do not cite multiple references when not necessary to the decision.

The hearing was transcribed in three volumes. The record closed on June 8, 2022, after both parties filed their post-hearing briefs.

FINDINGS OF FACT

Based upon the testimony and other evidence in the record and the reasonable inferences drawn from them, as well as my assessment of witness credibility, I make the following findings of fact:

1. Emily Strehle, D.O. graduated from medical school and completed her residency at Mercy Hospital in Chicago, Illinois. She is Board certified in obstetrics and gynecology. (Tr. II: 97-98.)

2. Dr. Strehle is licensed to practice medicine in Massachusetts (since 2011). She is a partner in her clinical practice with privileges at Emerson Hospital in Concord, Massachusetts. (Tr. II: 97.) She has continued to practice medicine during the Board's investigation, after the Board issued the Statement of Allegations, and into the present.

3. Dr. Strehle has had no other complaints or issues brought before the Board or Emerson Hospital regarding her patient care. She voluntarily went through an audit by a Board-approved entity who found her 100% compliant. The audit was a record review and a clinical practice review. (Tr. II: 136-137.)

Dr. Strehle's Treatment of Patient A

4. Dr. Strehle saw Patient A for a gynecological checkup on August 15, 2012. She was a new patient. (Tr. II: 101-102; Ex. 2 at 2-3.)[3]

[3] I am aware that a civil trial brought by Patient A against Dr. Strehle occurred. On September 8, 2021, Board Counsel filed a letter dated March 8, 2016, with his opposition to Dr. Strehle's motion to dismiss, which stated: "The fact that a jury in a civil trial for malpractice may have rendered a verdict against Dr. Strehle is not a factor in my recommendation to the Complaint Committee." Board Counsel did not present a transcript or in any way indicate an intent to rely on evidence adduced at the civil trial.

5. Patient A's stated reason for scheduling an appointment was a concern about osteoporosis. (Tr. I: 21-22, 23.)

6. Based on her history, but contrary to her testimony, Patient A was not proactive about her health. She apparently had no primary care provider. Patient A had not been seen by a gynecologist in over 10 years. She had not had a colonoscopy or mammogram. She had completed menopause about a year prior to her appointment. (Tr. 1:21-22, 25; Tr. II: 101-102; Ex. 2 at 2-3.)

7. During the examination, Dr. Strehle observed a cervical mass approximately one centimeter long, which was "soft, sort of fleshy and it had a pinkish tinge to it." Based on its size and appearance, she concluded the mass was a cervical polyp. (Tr. II: 104, 106; Ex. 2 at 3.)

8. Patient A states that Dr. Strehle never told her at her first appointment that a polyp can remain in place if it is asymptomatic and conversely, if it is removed it can be tested to see if it is benign or cancerous. She denied being told the risks of the procedure were minor bleeding and the possibility of infection. (Tr. I: 96-97.)

9. After Dr. Strehle discussed the risks and benefits associated with removal or leaving the polyp in place, Patient A declined removal. This discussion and Patient A's response comprised a verbal informed consent. Dr. Strehle noted in Patient A's chart the polyp was "asymptomatic and no bleeding." Patient A was counseled to return if she had any vaginal bleeding. (Tr. II: 104-105; Ex. 2 at 3.)

10. Patient A viewed Dr. Strehle as abrupt, pushy, and non-responsive to her questions. She said both that Dr. Strehle represented there was no risk and that she was adamant about the risk of infection. These statements contradict each other. Patient A decided not to have

the polyp removed that day because she said Dr. Strehle would not explain the procedure to her. (Tr. I: 22-25, 95, 96.)

11. Patient A said when she asked Dr. Strehle about calcium supplements, the doctor pointed to some literature and brushed her off. Patient A did not explain why she chose to see an OB/GYN about osteoporosis concerns. (Tr. I: 24-25.)

12. Patient A was informed of her normal pap smear results on August 23, 2012. (Tr. I: 25; Ex. 2 at 5.)

13. Patient A called Dr. Strehle's office on August 23, 2012, and inquired whether she should have the polyp removed. Through her receptionist, Dr. Strehle relayed that the polyp need to be removed only if it was bleeding. Patient A received a call back, although she denied it. (Tr. I: 97, Tr. II: 106-107; Ex. 2 at 6.)

14. Even when there is no bleeding, most patients decide to have a polyp removed. (Tr. II: 42, 107; Tr. III: 26, 28.)

15. Patient A maintained that she did not get a call back when she phoned the office, which bothered her. Nonetheless, she made a follow up appointment. (Tr. I: 25.)

16. Patient A returned on September 11, 2012, at 8:30 AM to have the polyp removed. (Tr. I: 25; Tr. II: 108-107; Ex. 2 at 15.)

17. Patient A described Dr. Strehle as irritated and brusque. With no exam, pain medication, or other preliminaries, according to Patient A, Dr. Strehle had her lay on the table and "went inside me and tore it out, which was incredibly painful." (Tr. I: 26-27.)

18. Patient A said she was near tears, in pain, bleeding, while Dr. Strehle was pushing inside her with the Monsel's solution and saying, "I'm having trouble getting the bleed[ing] to

stop." She stated Dr. Strehle told her to expect some bleeding, that Monsel's solution should stop it, handed her a pad, and left the room. (Tr. I: 26, 28-29.)

19. Patient A stated that Dr. Strehle told her she thought the mass was a fibroid, which frightened her because a friend had fibroids and so Patient A knew they were not taken out in an office. (Tr. I: 29.)

20. I do not credit Patient A's version of the appointment on the morning of September 11, 2012.[4]

21. At Patient A's appointment on September 11, Dr. Strehle easily twisted off the polyp with a ring forceps. The mass was approximately 3 centimeters in size, larger than it was on Patient A's initial visit. It was soft and fleshy pink in color and located in the cervix. (Tr. II: 109, 110-112; Ex. 2 at 15.)

22. Once she removed the mass, Dr. Strehle thought it could be a fibroid based on its size, although polyps can also be 3 cm in size. (Tr. II: 39, 108-109.)

23. Patient A did not complain of pain during the procedure. (Tr. II: 112.)

24. On August 15 and September 11, 2012, Dr. Strehle provided Patient A with the information necessary for her to decide to have the procedure or not, and she obtained verbal consent from Patient A for the polyp removal on September 11. (Tr. II: 112.)

25. Under Assessment and Plan, Dr. Strehle's note reads: "54-year-old with cervical polyp, removed and sent to path, will follow up." (Tr. II: 108; Ex. 2 at 15.)

26. Under GYN Procedure(s), the Note states: approx. 3 cm polyp—suspect possible myoma.... The Pre-Op and Post-Op Diagnosis both read: "cervical polyp--?? myoma."[5] (Ex. 2 at 15.)

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[4] See Discussion.

[5] Myoma is the medical term for what is more commonly referred to as a fibroid.

27. Dr. Strehle usually documented the verbal informed consent process in the patient's record. In this case, she did not. (Tr. II: 114; Ex. 2 at 15.)

28. Patient A experienced minimal bleeding immediately after the polyp's removal. Dr. Strehle administered Monsel's solution, a commonly used chemical, which stopped the bleeding. (Tr. II: 114-115; Ex. 2 at 15.)

29. Dr. Strehle told Patient A to take it easy, not to lift anything heavy or exercise, and not to put anything in her vagina for three days. (Tr. II: 115.)

30. Patient A said she was told only to take it easy. (Tr. I: 99.)

31. On her way home, Patient A stopped at Erikson Grain and "picked up some dog bones or something for my dog" (a St. Bernard) and went home. Patient A likely bent down and picked up dog food, which likely was heavy given the size of her dog. (Tr. I: 21, 30, 100-101; Tr. II: 66, 83; Ex. 2 at 16.)

32. Patient A said she was bleeding when she left the office and had bled through her clothes by the time she got home. She said she called her sister, a surgeon, who advised her to lie down and, if the bleeding did not stop, said her doctor would probably want to see her back. (Tr. I: 33-34, 99.)

33. Patient A did not follow Dr. Strehle's instructions to contact her if she experienced bleeding. Patient A stated she laid down, trying to deny the amount of blood. She fell asleep and when she woke up about 1:30 PM she said there was "blood everywhere." (Tr. I: 34-35.)

34. Patient A said she was "terrified and afraid" and "in a panic" about going back to see Dr. Strehle. She did so, she said, because her sister told her to. When she called the office,

she said she had to argue with the receptionist about coming in without an appointment, even though she told them she was bleeding heavily. (Tr. I: 34, 35-36.)

35. She had her son drive her, she relayed, because she was "white as a ghost" and afraid she would "black out" with the blood loss. She said she was bleeding through her clothes after the seven-minute drive to the hospital.[6] (Tr. I: 36, 37.)

36. Patient A said she spoke with Dr. Strehle, but she was mistaken. Dr. Strehle relayed a message for Patient A to come into the office through her office assistant. (Tr. I: 37, 101-102.)

37. According to Patient A, she was taken into a room by an assistant, Dr. Strehle came in and, without taking vitals, obtaining consent, or saying anything, she "...just shoved this thing up and then turning the machine on and didn't tell me what she was doing, and apparently it was cautery. ...[It] was so painful. I kept saying, I can't stand this...and they totally ignored me in my distress, and I kept saying that. ...[I]t was so horrific. I can't tell you how bad it was." (Tr. I: 39-40, 42, 46.)

38. According to Patient A, Dr. Strehle stopped, yelled for a larger needle, the assistant returned with one and Dr. Strehle injected lidocaine into Patient A's cervix without telling Patient A what she was doing. Patient A said she thought she was being "sewed up." (Tr. I: 41, 45, 46.)

39. Patient A was taken to the OR at Emerson Hospital in a wheelchair. She said that in the OR area she was consented for a blood transfusion and anesthesiology before Dr. Strehle spoke with her about consent for the surgical procedures. (Tr. I: 47, 48.) The hospital records

[6] Dr. Strehle's office was in the Emerson Hospital building. (Tr. I: 37-38.)

show that she spoke with Dr. Strehle before she spoke with the anesthesiologist. (Ex. 1, Set 2 at 14, 16.)

40. Patient A stated that the only procedures Dr. Strehle mentioned were hysteroscopy and stitches. She stated that Dr. Strehle showed her only a signature sheet, which she could not read because she was feeling the effects of the sedation medication. She added that after she had signed the consent form, Dr. Strehle leaned over and told her: "We might have to do a hysterectomy." In response, Patient A said: "[A]ll I could think in my head was no, and I blacked out...." (Tr. I: 56-57, 58, 59.)

41. Patient A maintained that her husband and son could not find her until after the surgery. (Tr. I: 60.)

42. I do not credit Patient A's version of the afternoon office appointment and surgery on September 11, 2012.[7]

43. At 2:56 PM Patient A phoned Dr. Strehle's office and reported she was bleeding. The office note for the call stated that Patient A said she bent down to pick up something and started bleeding very heavily with some clots and cramping. After speaking with Dr. Strehle at 3:27 PM, office personnel phoned Patient A and told her to come to the office. She arrived about 4:00 PM. (Tr. II: 115-116; Ex. 2 at 16.)

44. Dr. Strehle administered lidocaine by injection prior to the cauterization. (Tr. II: 124.)

45. The cautery attempt and transport took about 10-15 minutes before Dr. Strehle and Patient A arrived in the pre-op area at Emerson Hospital at 4:09 PM. (Tr. II: 117; Ex. 1, Set 1 at 2.)

[7] See Discussion.

46. Dr. Strehle reviewed an OB-GYN informed consent form with Patient A. She filled in by hand the blank spaces on the form. She discussed the possible surgical procedures with Patient A, including a total abdominal hysterectomy. Where the form used medical terminology, she described the procedure in layperson's terms. She answered Patient A's questions. Dr. Strehle and Patient A signed the form on its reverse side at 4:30 PM. (Tr. II: 121-123; Ex. 1, Set 1 at 13-14.)

47. Patient A's consent form for anesthesia was completed at 5:15 PM. She was not under the influence of anesthesia when Dr. Strehle reviewed the surgical informed consent form with her at 4:30 PM. (Tr. II: 118-119; Ex.1, Set 2 at 14, 16.)

48. Dr. Strehle left a voice message for Patient A's husband before and after the surgery. She spoke with Patient A's sister, the surgeon, before and after the surgery. (Tr. II: 124-125.)

49. Dr. Strehle documented the failed cauterization attempt in the Emerson Hospital record at 5:00 PM rather than in her office records because Patient A's uncontrolled bleeding constituted an "emergent situation." (Tr. II: 120-121; Ex. 1, Set 1 at 4.)

50. Dr. Kramer, who was Dr. Strehle's partner, assisted her during Patient A's surgery, which turned out to be an abdominal hysterectomy. Dr. Kramer agreed with the treatment plan and was very supportive. (Tr. II: 125.)

51. The American College of Obstetrics and Gynecology (ACOG) guideline, which recommends that hysterectomies be performed vaginally, applies to elective procedures, which this was not. (Tr. II: 125.)

52. Patient A stated that her night in the hospital was "incredibly painful. I was alone and I was terrified because I didn't understand how this happened because I didn't consent to that and there was no need for me to have a hysterectomy." (Tr. I: 61.)

53. Patient A said that when Dr. Strehle saw her the next morning, she blamed Patient A for needing surgery. Patient A said she did not respond; she just wanted to leave the hospital. (Tr. I: 62, 66.)

54. Patient A said she was "completely yellow, even to my eyeballs, covered in hives, and ... so swollen I couldn't get any clothes on." She said her husband was horrified by her appearance. She thought about escaping because she feared Dr. Strehle would do something else without her consent. Patient A's hospital records say nothing about yellow skin or jaundice, hives, or swelling. I infer that Patient A suspected she was having an allergic reaction, perhaps to anesthesia used during surgery. (Tr. I: 66-67; Ex. 1, Set 1 at 6, Set 3 at 3.)

55. Dr. Strehle returned the following morning and told Patient A she could leave the hospital that day, and she should make an appointment to have the staples removed. (Tr. I: 69-70.)

56. According to Patient A, the staples were removed about a week later, but it was too soon. She was in pain. When Patient A asked Dr. Strehle a question about getting a binder to wear, Patient A said Dr. Strehle responded: "I don't care what you do." (Tr. I: 70-71.)

57. Patient A's husband met alone with Dr. Strehle and thanked her; Patient A said she was furious he did so. (Tr. I: 71-72.)

58. Patient A did not return to Dr. Strehle for medical care. (Tr. I: 72.)

59. I do not credit Patient A's version of her hospital stay and return to Dr. Strehle's office to have her staples removed.[8]

60. Dr. Strehle visited Patient A following the surgery. She explained the surgery that had to be performed. She visited again the next morning. According to her note, Patient A appeared to be doing well, her pain was well controlled, she did not appear to be in much discomfort, and she was tolerating a clear liquid diet. (Tr. II: 127; Ex. 1, Set 1 at 6.)

61. The plan for that first day post-op was to have Patient A up and walking, to remove the Foley catheter, to discontinue the self-administered pain pump and start oral pain medication, and to introduce a regular diet. (Tr. II: 128.)

62. On post-op day two Dr. Strehle visited again. Patient A's recovery continued to progress. Her pain was well-controlled, and she did not want narcotics. She had no vaginal bleeding. (Tr. II: 129; Ex. 1, Set 1 at 6.)

63. On the following day, September 14, 2012, Patient A and her husband went to Dr. Strehle's office to have Patient A's staples removed. Patient A was doing well. Dr. Strehle performed a physical examination, and the staples were removed. Dr. Strehle provided Patient A with after-care instructions, reviewed precautions, and recommended a follow-up visit in two weeks. (Tr. II: 130-131; Ex. 2 at 28-29.)

64. Patient A's husband asked to see Dr. Strehle separately before the couple left the office. He thanked Dr. Strehle for her "excellent care" of Patient A. Dr. Strehle also received a thank you card from Patient A after the September 14 visit. (Tr. II: 132.)

65. Dr. Strehle did not tell Patient A the surgery was her fault or suggest fault in any other way. Dr. Strehle did not admit to "screwing up." (Tr. II: 127, 128, 130.)

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[8] See Discussion.

66. Patient A did not suggest to Dr. Strehle in any way that she feared her, that she had done something wrong, or had concerns about her care. (Tr. II: 129, 128.)

67. The Peer Review Committee at Emerson Hospital reviewed this case and concluded that Dr. Strehle's care of Patient A met the appropriate standard of care. (Tr. II: 133; Ex. 5.)

68. Patient A recounted her medical condition following her surgery. She also described the significant negative impact her condition has had on her daily life. (Tr. I: 72-85, 112-117.)

Testimony of Sharon MacMillan, M.D.

69. Sharon MacMillan, M.D., a Board-certified obstetrician/gynecologist, has practiced for about 30 years, primarily in Springfield, MA. In February 2012, Dr. MacMillan voluntarily ceased her practice in obstetrics to concentrate on her gynecological practice. (Tr. I: 134, 138, 145, 192, 193-195.)

70. Dr. MacMillan has performed hundreds of hysterectomies, both vaginal and abdominal, though she stopped performing surgeries in 2019. She has routinely removed polyps, "a very common procedure." (Tr. I: 145, 146, 193.)

71. The Board asked Dr. MacMillan to review the office and hospital records in this matter and give an opinion about whether Dr. Strehle met the standard of care for the time. Dr. MacMillan found that she did not. She wrote a report that is not in the record. (Tr. I: 147-148.)

72. Dr. MacMillan opined that on Patient A's second visit, it was apparent that the mass was a fibroid, not a polyp. She based this on the size and appearance of the mass, as described in Dr. Strehle's records and in the pathology report. In her view, even if what Dr. Strehle saw was a soft, pink, fleshy mass, it would have been apparent once she placed the ring

forceps on it that it was not a polyp. "If you had a mass, a fibroid the size they're talking about, it would literally be impossible to close the ring forceps or come anywhere close to closing it...the haptic feedback after you put the ring forceps on it would be undeniable." (Tr. I: 148-149, 156.)

73. In Dr. MacMillan's experience, polyps and fibroids are very different from each other. It is very hard to mistake one for the other visually. They also feel different--while polyps are very soft, fibroids are very dense and solid. Dr. MacMillan had seen hundreds of polyps and abdominal fibroids. Cervical or vaginal fibroids are not common; Dr. MacMillan has seen three or four in her 30-year practice. Cervical polyps are found more commonly in the cervical canal than fibroids. (Tr. I: 148, 149, 151, 204, 205.)

74. Polyps are removed by placing ring forceps on either side of it, closing and locking the forceps, twisting a few times, and pulling it out through the vagina. It is an office procedure. (Tr. I: 152-153.)

75. Fibroids are rarely removed in the office. They are attached to the uterine wall by a long, thin blood vessel. The blood supply must be visualized and controlled during the removal by clamping the blood vessel behind where it is cut. Otherwise, it likely will retract back into the uterus. Dr. MacMillan would never try to remove a fibroid in the office. (Tr. I: 153-154.)

76. Dr. MacMillan reiterated that, on Patient A's second visit, from the size of the mass, "it was not possible, in my opinion, to think that it was a polyp at that point. It was too large and too solid. It just was. But she removed it anyway." (Tr. I: 156.)

77. Dr. MacMillan could tell a fibroid from a polyp "100% of the time." (Tr. I: 225.)

78. Dr. MacMillan noted that when the mass was removed, Dr. Strehle's notes show that "it seems like she was rather certain it was a fibroid." Dr. MacMillan assumed the tether of blood supply sprung back into the uterus and went into spasm. It did not start bleeding right

away because of the spasm or because Monsel's solution was applied, the latter of which was not inappropriate. (Tr. I: 157-158.)

79. Dr. MacMillan noted that, because the source of the bleeding was inside the uterus, the attempted cautery of the cervix in the office and at the hospital would not, and could not, stop the bleeding. (Tr. I: 158-159, 172.)

80. Dr. MacMillan observed that an alternative procedure to stop the bleeding could have been tried at this point if the uterus was recognized as the source of the bleeding. A Foley balloon placed in the uterus and blown up would have provided sufficient pressure to stop the bleeding in most cases. Dr. MacMillan had used this procedure once before when she had a similar case of bleeding. She considered it "well described and referenced a 20-case study from 1983." (Tr. I: 159-160, 172.)

81. Dr. MacMillan observed that according to the hospital record, a hysteroscopy, the visual examination of the cervix and interior of the uterus with a camera, revealed that the bleeding was from the interior part of the cervix. Consequently, a hysterectomy was deemed necessary. (Tr. I: 159, 164.)

82. Dr. MacMillan opined that given Patient A's size, history, and position on the operating table, a vaginal hysterectomy was recommended under the ACOG guidelines. She understood the estimated blood loss during surgery was 200 ccs, which is within normal range of 100-200 ccs for an abdominal hysterectomy. She concluded there was no excessive bleeding in the vagina such that Dr. Strehle and Dr. Kramer could not see the field. Dr. MacMillan did not account for any blood loss Patient A experienced before the surgery. (Tr. I: 164, 165, 172-173.)

83. Dr. MacMillan opined that Dr. Strehle did not meet the standard of care in 2012 for the fibroid removal by using cautery to the cervix when the bleeding was likely from within

the uterus, by failing to use a Foley balloon to stop the bleeding, by performing an abdominal rather than a vaginal hysterectomy, and by failing to document the cautery and the informed consent for the fibroid removal. (Tr. I: 166, 171, 172,173, 228.)

84. At one point during the hearing, Dr. MacMillan appeared to reconsider her opinion. The fibroid removal was "definitely" below the standard of care, but she questioned Dr. Strehle's skill level for a vaginal hysterectomy. Cautery and failing to use a Foley balloon were unwise or poor management. She wanted to give people the "benefit of the doubt." She returned to her original opinion, however. (Tr. I: 208-209, 212, 225, 228.)

85. Dr. MacMillan's practice is to obtain written consent from a patient before removing a polyp. She uses a form the patient can read and ask questions about, and both sign the document in front of a witness. (Tr. I:160-161.)

86. Verbal consent is permitted if documented in the chart, including a description of what a physician discussed with the patient. (Tr. I:161, 201-202.)

87. Dr. MacMillan said, without explanation, that obtaining informed consent was required by the American Medical Association, ACOG, and "Massachusetts guidelines." (Tr. I:161.)

88. Dr. MacMillan did not see a consent form for the polyp removal or cautery procedure in Patient A's file from Dr. Strehle's office. She saw a note about the polyp removal in the office file. She saw a notation about the cautery procedure in Patient A's hospital records. (Tr. I:162.)

Testimony of Thomas L. Beatty, Jr., M.D.

89. Thomas L. Beatty, Jr., M.D. is a board-certified obstetrician/gynecologist with 35 years of experience. He is the OB/GYN Chair at Newton-Wellesley Hospital where he has

academic teaching responsibilities as well. He is OB/GYN Vice Chair at Brigham and Women's Hospital. (Tr. III: 9-12.)

90. Dr. Beatty sits on or chairs several committees concerned with the quality and safety of patient care, including one that evaluates certain cases where complications occur. He is familiar with an ACOG policy that distinguishes medical malpractice from medical maloccurence and defines the latter as a bad or undesirable outcome that is unrelated to the quality of care provided. He has seen such cases. (Tr. III:12-14.)

91. Dr. Beatty teaches his students to document verbal consent in a patient record as it is best practice. Viewing informed consent as a process, he explained that there was "evidence...that the process of informed consent was performed in this case by virtue of the [initial] visit..., the follow-up phone call, and [Patient A's] coming back for the express purpose of having the polyp removed." He also inferred that the note in the record stating "patient declined removal" was indicative of an informed discussion about removal. (Tr. III: 49, 52-53; Ex. 2, 3.)

92. As of 2012, Dr. Beatty estimated he had removed at least 600 cervical polyps and performed close to 1,000 abdominal hysterectomies. (Tr. III:15-16.)

93. Dr. Beatty noted that while the appearance of cervical polyps varies, most are "sort of reddish, a little fleshy colored, oblong...[and] several millimeters to several centimeters" in size. Usually, they are attached via a thin stalk that can easily be twisted off. Cervical polyps occur far more often, statistically, than cervical fibroids. (Tr. III:17-18, 19.)

94. Cervical polyps are usually attached to the cervical canal, and some extend beyond the cervix into the vagina. (Tr. III: 19.)

95. There is some overlap in the appearance of cervical polyps and fibroids. Fibrous polyps are firmer and less red. Fibroids that are degenerating may appear less red. (Tr. III: 17, 63.)

96. Fibroids are found more often in the uterine canal but may also appear in the wall of the uterus, including the inner wall where they may descend into the endometrial cavity. They may sometimes rise from the lower uterine cervix or endocervical canal. They may prolapse through the cervix. (Tr. III: 17, 63.)

97. Often the entire cervical mass, whether polyp or fibroid, cannot be visualized before removal, but that is not necessary. A physician can also feel the size of the mass and location of the stalk with her instrument. (Tr. III: 73-75.)

98. There are some circumstances when a fibroid can be removed without controlling the blood supply, including when the mass appears to be a polyp and turns out to be a fibroid. (Tr. III: 76.)

99. Dr. Beatty has removed approximately 300-400 fibroids in his 35 years of practice. (Tr. III: 61.)

100. The one-centimeter polyp documented in Patient A's chart is within the normal size range. It was described as asymptomatic; therefore, it could remain in place. Dr. Strehle's instruction to Patient A to return if she was bleeding, both at her appointment and on August 23 when Patient A called the office, was appropriate. (Tr. III: 26-27, 28; Ex. 2 at 2, 3.)

101. While watching and waiting to see if a mass changes in appearance may sometimes be reasonable, it was more reasonable in this case to remove the polyp because Patient A, like many other women, had returned to the office for that purpose. (Tr. III: 81-82.)

102. A one-to two-centimeter polyp is unlikely to cause a cervix to appear patulous, that is, dilated. (Tr. III: 99, 102.)

103. Polyps are usually discovered during an exam, when it would be impractical and uncomfortable to stop and start again. Typically, then, a physician practicing in 2012 would discuss the risks and benefits with the patient, obtain verbal consent and remove the polyp. Once removed, the mass would be sent to pathology for identification. (Tr. III:19-20.)

104. Once the blood supply to a polyp is removed it becomes paler in appearance. During the time period from removal to when a pathologist examines the polyp, it continues to become paler. In this case, the pathologist reviewed it two days after removal. (Tr. III: 31.)

105. Based on Dr. Strehle's notations following "pre-op" and "post-op" diagnoses in the record on September 11, Dr. Beatty does not know whether Dr. Strehle knew there was a possibility before the removal that the mass was a fibroid. (Tr. III: 54-57; Ex. 2 at 15.)

106. When asked to assume that Dr. Strehle informed Patient A after removal that the mass might be a fibroid and would be sent to pathology and asked whether that was appropriate, Dr. Beatty opined that it was appropriate and best practice to be transparent with patients. (Tr. III: 32.)

107. In Dr. Beatty's experience, a procedure note is written after a physician has removed a mass and thus may include information not observable at the start of the procedure. (Tr. III: 29, 72.)

108. Dr. Beatty opined that Dr. Strehle complied with the standard of care by "removing...what appeared to be a cervical polyp by its characteristics and size, and by removing it, grasping it with...a ring forceps or an instrument so that she could simply twist it. And with a simple twist it was removed, as virtually all polyps are removed." (Tr. III: 30, 82.)

109. Dr. Beatty also opined that Dr. Strehle complied with the standard of care and the ACOG opinion regarding informed consent that were in effect in 2012 regarding her removal of the polyp. His understanding is that the ACOG opinion in effect in 2012 did not require that verbal consent be documented in the record. (Tr. III: 30-31, 48, 103-104.)

110. Dr. Beatty opined that Dr. Strehle's discharge instructions that included precautions to prevent bleeding, were appropriate for the type of procedure she had undergone. (Tr. III: 32-33.)

111. Dr. Beatty was asked to assume that Patient A left Dr. Strehle's office at about 9:00 AM, called at about 3:00 PM and reported she bent down to pick up something, started bleeding heavily with some clots the size of fists, was told by her sister to stay home and rest, and then bled for about six hours. Dr. Beatty was asked whether it was within the standard of care to treat this as an emergent or urgent procedure and to attempt to stop the bleeding by cautery, and he opined that it was, given Patient A's history of bleeding. (Tr. III: 37-38.)

112. Dr. Beatty opined that if the cautery in the office was not successful, the circumstances required that the patient be taken to the operating room for a hysteroscopy and hysterectomy, if necessary. (Tr. III: 38.)

113. Dr. Beatty opined that it was common practice for OB/GYN physicians not to document an unsuccessful cautery in an office note when one's focus is on moving quickly to transport the patient to the OR and have resources in place when you arrive. The unsuccessful cautery can be documented in the hospital record, as it was in this case. (Tr. III: 39, 40-41, 83; Ex. 1, Set 1 at 4.)

114. There is time for such documentation and obtaining informed consent because a patient is being attended to by other clinicians before the surgery can begin. (Tr. III: 84, 85.)

115. The surgical informed consent form, which Dr. Strehle completed and reviewed with Patient A, listed the expected potential procedures that Patient A could undergo, from less invasive to more invasive, including total abdominal hysterectomy. (Tr. 40, 44; Ex. 1; Set 1 at 13-14.)

116. Dr. Beatty was familiar with the ACOG guideline that discussed a preference for vaginal hysterectomies. He described the various factors to consider when deciding on the best route for each patient, noting that most hysterectomies are scheduled ahead of time, which is one of the factors to consider. In an emergency, he said the best route is best determined by the physicians present who can decide the most efficient and safest route. (Tr. III: 21-22.)

117. The ability to see the vagina and have access to the uterus through it are considerations that can affect a physician's ability to do a vaginal hysterectomy. (Tr. III: 22.)

118. Whether the procedure is polyp removal or a hysterectomy, a physician is expected to use reasonable judgement in diagnosis and treatment. (Tr. III: 20, 23, 105.)

119. Dr. Beatty is familiar with the use of an intrauterine balloon to stop bleeding. Its use for the type of bleeding Patient A was experiencing was not the standard of care in 2012. (Tr. III: 43.)

120. No ACOG bulletins refer to the use of an intrauterine balloon. Its more common use now is to control postpartum hemorrhage and, because of its success in this use, has been proposed as a possible option for other types of bleeding outside of pregnancy. Dr Beatty has not used it for gynecologic indication, only for postpartum indications. (Tr. III: 43, 89-90.)

121. Dr. Strehle complied with the standard of care by performing an emergency total abdominal hysterectomy where Patient A was bleeding uncontrollably, a second attempt at

cautery was unsuccessful, and, for this patient, an abdominal hysterectomy was most appropriate. (Tr. III: 44-45.)

122. Patient A's discharge on September 13, 2012, with staple removal on September 14, was a typical timeframe for a total abdominal hysterectomy. (Tr. III: 45.)

Testimony of Bradley J. Quade, M.D.

123. Bradley J. Quade, M.D. is a board-certified pathologist, with a subspecialty that includes gynecological, obstetrical, placental, and fetal pathology. He has 30 years of experience in the field. He prepared two reports concerning Patient A.[9] (Tr. III:113, 115.)

124. Dr. Quade has extensive publishing, peer review, lecture, and academic credentials. (Tr. III:115-118, 120.)

125. Dr. Quade has reviewed approximately 400-500 pathology slides of fibroids and of endometrial and endocervical polyps each year. (Tr. III:119.)

126. He has reviewed approximately the same number of slides concerning full hysterectomies. (Tr. III:119-120.)

127. It is not uncommon for a physician who sends a mass to Dr. Quade for analysis to tentatively identify it as a cervical polyp when it is a fibroid. (Tr. III:121-122, 123.)

128. Dr. Quade described the typical appearance of a cervical polyp as a "sort of teardrop shaped [mass] hanging from a stalk attached to the lining of the...endocervical canal or just on the outside of the cervix." It often is fleshy or pink colored. (Tr. III:123-124.)

129. A mass hanging into the cervix is more often a polyp. (Tr. III:124.)

130. When removed, the mass is placed in formalin, a preservative, which will cause the tissue to become paler, whiter, and rubbery. (Tr. III:124-125, 138.)

[9] Neither report is in the record.

131. Cervical polyps, as well as fibroids,[10] have a blood supply that passes through the stalk's tissue. Part of the diagnosis for a polyp is the presence of blood vessels in the stalk. A thin stalk can be twisted off, which interrupts the blood supply. (Tr. III:126-127.)

132. A mass fitting the description of the one Dr. Strehle removed is more likely to be thought of as a polyp by the clinician who removed it, as Dr. Strehle surmised. (Tr. III:127, 129-130; Ex. 2 at 35.)

133. The specimen, which had been in formalin for two days, was ultimately identified as a fibroid. (Tr. III:130; Ex. 2 at 35.)

134. Dr. Quade has often seen fibroids that are three centimeters, and a cervical polyp of that size is not unusual. (Tr. III:130.)

135. Dr. Quade opined that the mass would have appeared to Dr. Strehle as "covered by the uterine surfaces" and "endocervical epithelium" typical of the transition zone between the lower uterus and the high endocervix. The mass was in the endocervical canal, not the uterus. (Tr. III:131-132, 152.)

136. The same pathologist also reviewed the cervical and uterine tissue from the hysterectomy specimen. After reviewing the two reports, Dr. Quade opined that the stalk on the mass was very thin with a narrow diameter. (Tr. III:134-135; Ex. 2, 34.)

137. In the report, the cervical canal was described as patulous, or dilated. The dilation can occur for various reasons, including by hysteroscopy, which is the procedure Dr. Strehle used to try and locate the source of the bleeding. (Tr. III:135-136.)

[10] Uterine leiomyoma is another term for a fibroid. (Tr. III:123.)

DISCUSSION

The Board's Statement of Allegations sets out the legal basis for its proposed discipline of Dr. Strehle. The Board seeks to prove that Dr. Strehle:

- is guilty of conduct which places into question the physician's competence to practice medicine, including but not limited to gross misconduct in the practice of medicine or of 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, G.L. c. 112, § 5(c) and 243 CMR 1.03(5)(a)3;
- practiced medicine deceitfully, or engaged in conduct that has the capacity to deceive or defraud, 243 CMR 1.03(5)(a)10;[11]
- committed malpractice within the meaning of G.L. c. 112, § 61, 242 CMR 1.01(5)(a)17; or
- engaged in conduct that undermines the public confidence in the integrity of the medical profession. *Levy v. Bd. of Registration in Medicine*, 378 Mass. 519, 932 (1979); *Raymond v. Bd. of Registration in Medicine*, 387 Mass. 708, 713 (1982) (Board has authority to protect the image of the profession).

Patient A's Credibility

Patient A's testimony was contrary to Dr. Strehle's in virtually every respect. She did not describe a single positive or even neutral interaction with Dr. Strehle or her office. Her explanations for why she continued to see Dr. Strehle--my sister told me to, I tried to find other doctors--simply did not ring entirely true considering the very negative picture she has portrayed. Her complete negativity seemed forced. Some of her testimony struck me as exaggerated as if to heighten the negativity of her experience, such as the amount and type of bleeding she experienced following the removal of the fibroid. Her description of the cautery in Dr. Strehle's office sounds medieval.

[11] Under G.L. c. 112, § 5 eighth par. (h) the Board may discipline a physician for violating any rule or regulation of the Board, governing the practice of medicine.

Her testimony conflicts with the documentary evidence in many respects. When she called Dr. Strehle's office to ask about getting the polyp removed she said she did not get a call back, which was not true. She said she signed the surgical consent form after speaking with the anesthesiologist and receiving some sedation, which was not true. She described having jaundice and hives, when there is nothing in the hospital record to confirm this. While the amount of blood Patient A lost before surgery is not documented, she did not present at the office as someone who had lost the amount of blood she described.

I find Patient A's testimony unreliable for these reasons. Consequently, I give little weight to her version of events. Where her testimony and Dr. Strehle's conflict, I credit Dr. Strehle's testimony, particularly concerning informed consent.[12]

Dr. Strehle's Credibility

I found Dr. Strehle to be a reliable witness. She was knowledgeable, forthright, and answered questions directly even when the answer was not in her favor. Her testimony conformed to the documentary evidence.

Standard of Care

Generally, the standard of care is "the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession.... [A] specialist is held to the standard of care and skill of the average member of the medical profession practicing his specialty." *Palandjian v. Foster*, 446 Mass. 100, 105 (2006), citing *Brune v. Belinkoff*, 354 Mass. 102, 109 (1968); *see also Aweh v. Bd. of Registration in Medicine*, RM-20-0299 (DALA, May

[12] I say this understanding that Patient A experienced a medical procedure with a difficult, even traumatic, outcome. Her life is now circumscribed by her medical condition. She deserves our empathy. Nevertheless, my evaluation of witness credibility must be objective, even if it can appear harsh.

26, 2022), *adopted*, Final Decision and Order (Oct. 20, 2022). "Establishing the standard of care typically requires expert testimony." *Palandjian,* 446 Mass. at 105-106.

When deciding whether Dr. Strehle met the standard of care in diagnosing and treating Patient A, I give greater weight to the opinions expressed by Dr. Rosenblatt, Dr. Beatty, and Dr. Quade than the opinions of the Board's expert, Dr. MacMillan. Dr. Rosenblatt's and Dr. Beatty's opinions, elicited in the form set out in *Palandjian*, were supported by detailed explanations about the underlying facts in the office and Emerson Hospital medical records. Their opinions were also based in part on hypotheticals that assumed facts I have found to be true. *See Egan v. Bd. of Registration in Medicine*, Supreme Judicial Court, No. 82-421, Sept. 19, 1983 (Memorandum of Decision), slip op. at 3-4. Dr. Strehle's experts' testimonies were based on academic experience and medical practice that exposed them to a greater number of occasions to observe polyps and fibroids. They answered thoughtfully and fully.

Dr. Quade's testimony supported Dr. Strehle's initial view that the mass was a cervical polyp. Dr. Quade opined, based on the pathology reports of the mass, which turned out to be a fibroid, and of the hysterectomy, that the stalk on the fibroid was thin and narrow, and the mass was in the endocervical canal. His opinions support Dr. Strehle's observations and "feel" when she placed the forceps on the suspected polyp and discredit Dr. MacMillan's opinion.

Dr. MacMillan had a lengthy career in a city practice. Her observations of polyps and fibroids were more limited than those of Dr. Rosenblatt and Dr. Beatty. They did not opine that it was below the standard of care to remove a fibroid in a physician's office, as Dr. MacMillan did. She opined that it was difficult to mistake a polyp for a fibroid visually and difficult to mistake the texture of one for the other when you had forceps around it. Her description of the mass appeared more like that described by Dr. Quade after it was prepared for pathology. She

appeared unaware that the mass would appear whiter and rubberier after placement in formalin. In short, she did not account for a wider variation in the texture and appearance of polyps and fibroids as did Dr. Rosenblatt and Dr. Beatty. What she described was also different from what Dr. Strehle observed and felt.

Dr. MacMillan's opinion appeared to be based on her personal assessment of what met the standard of care, rather than that of the average qualified practitioner. I applaud Dr. MacMillan for her high standards, but the opinion she is asked to provide is not based on her personal standard but a more objective one that includes the practices of all practitioners. The standard of care is based on the care that the average qualified physician would provide in similar circumstances; the actions that a particular physician, no matter how skilled, would have taken are not determinative. *Palandjian,* 446 Mass. at 104-105.

I suspect that this caused her difficulty when answering hypothetical questions and led to some uncertainty in her opinion. She ended up retreating from her earlier opinion and saying there was one act of negligence, the removal of the fibroid, because she wanted to give everyone the benefit of doubt. She later returned to her earlier opinion.

Alleged Offenses

Conduct which places into question the physician's competence to practice medicine (243 CMR 1.03(5)(a)3.)

In *Hellman v. Bd. of Registration in Medicine*, 404 Mass. 800 (1989), the Supreme Judicial Court ("SJC") defined the word "misconduct" as follows:

> "Misconduct," in general, is improper conduct or wrong behavior, but as used in speech and in law it implies that the conduct complained of was willed and intentional. It is more than that conduct which comes about by reason of error of judgment or lack of diligence. It involves intentional wrongdoing or lack of concern for one's conduct. Whether or not an act constitutes misconduct must be

> determined from the facts surrounding the act, the nature of the act, and the intention of the actor.

404 Mass. at 804 (internal quotations and citation omitted). Thus, in order for behavior to constitute misconduct, it must involve "intentional wrongdoing or lack of concern for one's conduct," and one must examine "the intention of the actor." *Id.*

On the other hand, "gross misconduct" refers to conduct that is "flagrant and extreme.... It is an act or omission respecting legal duty of an aggravated character.... It is a heedless and palpable violation of legal duty respecting the rights of others" (citations omitted). *Hellman*, 404 Mass. at 804.

Negligence occurs when a physician "fail[s] to meet generally accepted standards of care within the medical community." *Bd. of Registration in Med. v. Osei-Tutu*, RM-07-64 (DALA Jul. 9, 2008, *adopted* Feb. 25, 2009). A physician who provides medical care below the standard of care has acted negligently. *Palandjian,* 446 Mass. at 112. The Board may not discipline a physician for a single act of negligence. *Bd. of Registration in Medicine v. Peters*, RM-20-0299, Final Decision and Order (Feb. 17, 2022.) citing *Edinburgh v. Bd. of Registration in Medicine*, 89-3-TR (Dec. 18, 1991); *Egan, slip op.* at 20.

The Board argues that Dr. Strehle committed negligence on repeated occasions. According to its closing brief, the Board maintains that Dr. Strehle's "negligent practices include failing to obtain proper informed consent from Patient A for more than one medical procedure and failing to properly document items in the medical record." I have found that Dr. Strehle satisfied the standard of care in 2012 with respect to informed consent procedures.

The Board argues in its closing brief that Dr. Strehle's treatment of Patient A constitutes

> negligence on repeated occasions. Patient A went home from [Dr. Strehle's] office and returned approximately six hours later while bleeding profusely. [Dr. Strehle] used cautery to try to stop the bleeding, without success, and brought

> Patient A to the operating room. She ultimately performed a hysterectomy on Patient A. These missteps in the treatment of Patient A were repeated acts of negligence.

These actions were not missteps. They were within the standard of care and thus do not constitute repeated acts of negligence.

"Gross negligence is substantially and appreciably higher in magnitude than ordinary negligence....It is an act or omission respecting legal duty of an aggravated character as distinguished from a mere failure to exercise ordinary care. It is a heedless and palpable violation of legal duty respecting the rights of others.... Gross negligence is a manifestly smaller amount of watchfulness and circumspection than the circumstances require of a person of ordinary prudence." *Altman v. Aronson*, 231 Mass. 588, 591-592 (1919). "[S]ome of the more common indicia of gross negligence are set forth as 'deliberate inattention,' 'voluntary incurring of obvious risk,' 'impatience of reasonable restraint,' or 'persistence in a palpably negligent course of conduct over an appreciable period of time'") (citations omitted). *Parsons v. Ameri*, 97 Mass. App. Ct. 96, 108-109 (2020).

The Board argues that Dr. Strehle committed gross negligence when she "failed to fully inform Patient A of all known and relevant risks and benefits." I am not sure whether the Board means that in each separate instance where informed consent procedures were required (in the office and the operating room), Dr. Strehle was grossly negligent, or together they are a single instance of gross negligence. In any event, I have found that Dr. Strehle met the standard of care. Furthermore, there is no evidence of the behavior referenced in *Altman v. Aronson* or *Parsons v. Ameri* that would indicate Dr. Strehle acted with gross negligence.

Practiced medicine deceitfully, or engaged in conduct that has the capacity to deceive or defraud [243 CMR 1.03 (5)(a)10]

Based on its closing brief and its opposition to the petitioner's motion to dismiss, the Board's apparent theory about this regulatory violation is that: 1) Dr. Strehle deliberately did not document the cautery procedure in the office patient notes, and she intended to omit it as if the procedure had never occurred; and 2) Dr. Strehle did not sign the operating room consent form in Patient A's presence and added the hysterectomy procedure to the consent form after Patient A signed it and without informing her of the procedure.[13]

The Board has found that when a Respondent who "knowingly failed to reveal that he was to serve a jail sentence while on leave and the subject of that misstatement was obviously susceptible of his actual knowledge since he knew he was deliberately leaving out this information [and] he should have known that [his program] and the Board might think this information would be relevant to the decision each was to make" has engaged in conduct that has the capacity to deceive pursuant to 243 CMR 1.03(5)(a)10. *Bd. of Registration in Medicine v. Luna*, RM-20-0151, Final Decision and Order (Jun. 15, 2023). The Board's language here closely mirrors that in *Fisch v. Bd. of Registration in Medicine*, 37 Mass. 128 (2002). "[F]raudulent intent may be shown by proof that a party knowingly made a false statement and that the subject of that statement was susceptible of actual knowledge." *Id.* at 139 (citation omitted).

More recently, in *Welter v. Bd. of Registration in Medicine*, 490 Mass. 718 (2022), the SJC ruled that whether the doctor had engaged in "conduct that has the capacity to deceive or

[13] The Board did not allege that Dr. Strehle's failure to document Patient A's verbal consent in her office patient notes as a violation of 243 CMR 2.07(13)(a): A licensee shall maintain a medical record for each patient that is complete, timely, legible, and adequate to enable the licensee or any other health care provider to provide proper diagnosis and treatment.

defraud" was an "objective inquir[y] that do[es] not necessarily depend on intent, knowledge, materiality, or reliance." *Id.* at 727. As part of its reasoning, the Court contrasted this regulatory language with the "fraudulent procurement" portion of the same regulation, which "expressly require[s] intent or knowledge." *Id.* There is no suggestion in *Welter* that *Fisch* no longer is good law.

Employing an objective assessment of whether Dr. Strehle's conduct in failing to document the cautery procedure in her office patient notes and doing so in the hospital records is conduct that has the capacity to deceive, I conclude that it simply does not. Dr. Strehle documented the failed cautery attempt in the hospital record. She was focused on getting the patient to the operating room quickly. This is indicative of a doctor caring for her patient, not a coverup. No deceit was involved in obtaining consent for the various possible surgical procedures because I credit Dr. Strehle's testimony and not Patient A's, which the Board relied on.

Malpractice

Malpractice has three elements: i) a doctor-patient relationship; ii) failure to conform to good medical practice; and iii) injury that was caused by the defendant physician. *Doherty v. Hellman*, 406 Mass. 330, 333 (1999), citing *Kapp v. Ballantine*, 380 Mass. 186 (1980). *See also Matter of Suzanne Rothchild, M.D.*, Board of Registration in Medicine, Adjudicatory Case Nos. 2006-021 and 2008-002, Final Decision and Order (July 16, 2013). The Board has the burden of proving, by a preponderance of the evidence, all elements, including that Dr. Strehle's action or inaction caused Patient A's injury. The Board must establish that "but for" Dr. Strehle's act or omission Patient A would not have been injured. *Doull v. Foster*, 487 Mass. 1, 7-8 (2021).

The Board has not met its burden on this allegation. It presented no expert testimony on Patient A's injury nor on causation.

Public Confidence

Under *Levy v. Bd. of Registration and Discipline in Medicine*, 378 Mass. 519 (1979), the Board may discipline doctors who undermine the public confidence in the integrity of the medical profession. *Raymond v. Bd. of Registration in Medicine*, 387 Mass. 708, 713 (1982) (Board has authority to protect the image of the profession).

That the Board has not met its burden on this allegation is self-evident. No discussion is needed.

CONCLUSION

For the reasons stated above I find that Dr. Strehle acted within the standard of care during her treatment and care of Patient A. She did not commit conduct which places into question her competence to practice medicine, including negligence on repeated occasions and gross negligence; she did not practice medicine deceitfully or engage in conduct which has the capacity to deceive or defraud; she did not commit malpractice; nor did she undermine the public confidence in the integrity of the medical profession. I recommend the Board not discipline Dr. Strehle.

DIVISION OF ADMINISTRATIVE LAW APPEALS

Bonney Cashin

Bonney Cashin
Administrative Magistrate

DATED: July 16, 2024