COMMONWEALTH OF MASSACHUSETTS

**Division of Administrative Law Appeals**

**14 Summer Street, 4th Floor**

**Malden, MA 02148**

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**Board of Registration in Medicine**,

Petitioner

v. Docket No. RM-20-0299

**Victoria P. Peters, D.O.**,

Respondent

**Appearance for Petitioner**:

Lawrence Perchick, Esq.

Board of Registration in Medicine

200 Harvard Mill Square, Suite 300

Wakefield, MA 01880

**Appearance for Respondent**:

Jennifer Boyd Herlihy, Esq.

Adler, Cohen, Harvey, Wakeman & Guekguezian

75 Federal Street, 10th Floor

Boston, MA 02110

**Administrative Magistrate**:

Kenneth Bresler

**SUMMARY OF RECOMMENDED DECISION**

The Board of Registration in Medicine alleged that the respondent provided substandard care to a patient and that it was conduct that places into question her competence to practice medicine, such as gross misconduct, gross incompetence, gross negligence, or repeated negligence; malpractice; misconduct; or conduct that undermines the public confidence in the integrity of the medical profession. I find that the respondent committed one instance of malpractice for failing to order a test in August 2015 for a patient after the patient received a certain medication. I recommend that BRM discipline her as appropriate for one instance of malpractice.

**RECOMMENDED DECISION**

On July 16, 2020, the petitioner Board of Registration in Medicine (BRM) filed a Statement of Allegations against the respondent, Victoria P. Peters, D.O. On August 11, 2020, Dr. Peters denied the allegations.

I held a hearing on June 2 and 3, 2021, which was transcribed, at the Board of Registration in Medicine, 200 Harvard Mill Square, Suite 300, Wakefield, Massachusetts.

BRM called two witnesses: Dr. Peters and an expert, Dr. JoAnne Nowak, a palliative care specialist. Dr. Peters called an expert, Dr. Anthony M. Zizza, a geriatrician.

I accepted into evidence nine exhibits at the hearing and a tenth exhibit, a death certificate, after the hearing. Both parties submitted post-hearing briefs.

**Findings of Fact**

The experts

Dr. JoAnne Nowak

1. Dr. Nowak, whom BRM called as a witness, graduated from Boston University’s medical school. (Tr. II-10)

2. After medical school, Dr. Nowak completed an internship and residency in internal medicine at the Boston Veterans Administration Center. (Tr. II-10)

3. Internal medicine is the medical specialty of caring for adult patients, including problems of the circulatory system, neurologic system, and vascular system. (Tr. II-11)

4. Dr. Nowak had a fellowship in palliative medicine at Massachusetts General Hospital. (Tr. II-10)

5. Palliative care is a subspecialty of internal medicine. It involves caring for patients with serious illnesses that cannot be cured, focusing on managing their symptoms and their quality of life. (Tr. II-11, 13)

6. Hospice care is not the same as palliative care. Hospice medicine is a subspecialty of palliative care. (Tr. II-13)

7. Dr. Nowak has board certification in internal medicine, and palliative care and hospice. (Tr. II-11)

8. Dr. Nowak has worked for a medical practice in internal medicine, as Medical Director for Partners Hospital, and as an attending physician on palliative care for Massachusetts General Hospital. (Tr. II-10)

9. Dr. Nowak is the medical director of Merrimack Valley Hospice. (Tr. II-10)

10. Dr. Nowak has been licensed as a doctor in Massachusetts since 1982. She is also licensed as a doctor in New Hampshire and Maine. (Tr. II-15-16)

11. Dr. Nowak has had no lapses in her medical licenses. She has not been the subject of a complaint before the Board of Registration in Medicine or New Hampshire or Maine’s counterparts; has not been a defendant in a medical malpractice suit; and has not been the subject of an insurance claim related to her practice of medicine. (TR. II-16-17)

12. Dr. Nowak is familiar with adjusting patients’ Coumadin levels based on their International Normalized Ratio (INR) tests. In a typical week, she will do so one to five times. (Tr. II-30)

13. Dr. Nowak has issued hundreds of orders regarding Coumadin. (Tr. II-30)

Dr. Anthony M. Zizza

14. Dr. Zizza, whom Dr. Peters called an expert, graduated from the University of Massachusetts Medical School. (Tr. II-195)

15. Dr. Zizza did his internship and residency at Tufts Medical Center. (Tr. II-195)

16. Dr. Zizza did his fellowship in geriatrics at the Harvard program affiliated with Beth Israel Hospital. (Tr. II-194-95)

17. Dr. Zizza is board certified in internal medicine and geriatrics. (Tr. II-196)

18. Dr. Zizza has worked only in geriatrics. (Tr. II-199)

19. Dr. Zizza has been an attending physician in geriatric primary care at the Beth Israel Geriatric Primary Care Clinic. (Tr. II-199)

20. Dr. Zizza has worked as geriatrician in nursing homes. (Tr. II-200)

Dr. Victoria P. Peters and related topics

21. Dr. Peters is a doctor of osteopathy. (Tr. I-18)

22. Dr. Peters graduated from New York College of Osteopathic Medicine, now called the New York Institute of Technology (NYIT) College of Osteopathic Medicine, in 1987. (Tr. I-17-18; stipulation)

23. After graduating from NYIT, Dr. Peters engaged in a family medicine residency at Long Beach Memorial Hospital and a two-year geriatric fellowship in New Jersey. (Tr. I-18, 142)

24. Dr. Peters is certified by the American Osteopathic Association and the American College of Family Practitioners. (Tr. I-19)

25. Family medicine entails the care of children, adults, and pregnant women. (Tr. II-64)

26. Dr. Peters is also certified in geriatric medicine. (Tr. I-141; stipulation)

27. Geriatric medicine is a specialty entailing caring for the elderly, namely, patients older than 65. (Tr. I-141, II-64)

28. Geriatric medicine differs from palliative care medicine. Palliative care focuses on patients at the end of their lives, whether or not they are geriatric. (Tr. I-141-42)

29. In geriatric medicine, one clear-cut approach to a patient’s medical problems is rare. Practicing geriatric medicine is difficult because many medical studies do not include patients who are in their 80s and 90s, whereas geriatricians are treating patients who are that old. Rather than look to medical studies to determine how to treat patients, geriatricians often look to patients’ quality of life, preferences, and goals. (Tr. II-216)

30. For the last 30 years, Dr. Peters has worked almost exclusively with geriatric patients. (Tr. I-142)

31. Since 1992, Dr. Peters has been licensed to practice medicine in Massachusetts under license number 76807. (Stipulation)

32. In Summer 2015, Dr. Peters worked at a skilled nursing facility called Heritage Hall West in Agawam, Massachusetts. (Tr. I-19; stipulation)

33. Heritage Hall West had approximately 150 beds and four units. (Tr. I-21, 142)

34. The facility’s patients tended to be elderly. (Tr. I-25)

35. Dr. Peters was the medical director of the facility and the attending physician for approximately 70 of the patients in two units: the post-acute illness and transitional care unit, and the long-term care unit, which housed the hospice. (Tr. I-22, 23, 25, 142; stipulation)

Deep vein thrombosis and related topics

36. Deep vein thrombosis (DVT) entails a blood clot in a leg, which blocks the return of blood to the heart. (Tr. I-147)

37. DVT presents in a patient’s leg with redness, swelling, pain, palpable cords, and hardened edema. A palpable cord is a vein with a clot in it, which doctors and other health care personnel can feel. Hardened edema occurs when the blockage of blood flow from a leg causes the leg’s skin to become taut. (Tr. I-147-48)

38. It is important to treat DVT because it leads in a large majority of cases to pulmonary embolism. A pulmonary embolism occurs when a piece of clot breaks off and travels to the lung, causing serious problems, including death. (Tr. I-119, 149)

39. About 40% of patients with proximal DVTs, that is, in their thighs, develop a pulmonary embolism. About 70% of patients with a pulmonary embolism have a DVT. (Tr. II-120)

40. Pulmonary embolisms have been described as one of the most common preventable causes of death. (Tr. II-120)

41. An ultrasound examines proximal and distal veins, proximal being in the thigh, and distal being in the calf. (Tr. II-51)

42. A DVT in the thigh has a much higher probability of causing a pulmonary embolism. (Tr. II-51)

43. If an ultrasound purports to detect a DVT in a patient’s thigh, the accuracy is over 95%. (Tr. II-51-52)

44. If an ultrasound purports to detect a DVT in a patient’s calf, the accuracy is approximately 75%. (Tr. II-52)

45. When treating patients, doctors need to balance the risk of patients’ bleeding versus their risk of getting clots. (Tr. II-121)

46. The Wells Criteria is a set of clinical criteria, such as swelling, history of DVT, age, renal disease, and hypertension, which are assigned points and used to assess the probability of a DVT. It is used predominantly as a pretest indicator, that is, to assess whether a doctor should order more testing to determine the presence of a DVT. (Tr. II-60)

Dr. Peters, Patient MD, and more topics related to DVT

47. Dr. Peters was the attending physician for Patient MD, who stayed at Heritage Hall West from June 4 through August 30, 2015. (Tr. I-28; stipulation)

48. Patient MD was a 93-year-old woman. Her diagnoses included dementia, gout, congestive heart failure, and some episodes of syncope (fainting). (Tr. I-29; stipulation) (This recommended decision will refer to her as “the patient.”)

49. On June 15, 2015, Dr. Peters evaluated the patient for edema in her lower extremity, that is, her leg, and pain in her left lower extremity, that is, her left lower leg. (Ex. 1, p. 31; Tr. I-31; stipulation)[[1]](#footnote-1)

50. Around this time, the patient’s Wells Criteria was between 2 and 4, depending on how it was scored, indicating a moderate probability that she had a DVT. (Tr. II-61)

51. On June 17, 2015, Dr. Peters ordered an ultrasound and a D-Dimer test for the patient to determine if she had a DVT. (Ex. 1, p. 52; Tr. I-33-34; stipulation)

52. A D-Dimer test assesses clotting abnormalities. It is used as a screening test to determine if patients need further testing, such as ultrasound. (Tr. II-49)

53. On June 18, 2015, Dr. Peters wrote a progress note that she had diagnosed the patient’s condition as DVT. (Stipulation)

54. In the progress note on June 18, 2015, Dr. Peters wrote:

Given risk of NOT treating a DVT, and the fact that her exam is so positive, I would rather treat. Son[,] who is her HCP [health care proxy,] is in agreement with this plan.

(Ex. 1, p. 31)

55. The ultrasound was negative for DVT. (Tr. I-34)[[2]](#footnote-2)

56. Dr. Peters had had experience with mobile ultrasound machines being inaccurate. (Tr. I- 39)

57. The D-Dimer test result was elevated. (Tr. I-34)

58. A D-Dimer test can rule out DVT but an elevated test does not necessarily confirm the presence of DVT. (Tr. I-34)

59. Around this time, Dr. Peters examined the patient and determined that her lower left leg was red and swollen and had very hard palpable cords. (Tr. I-37)

60. Dr. Peters considered the examination to be “grossly positive” for DVT. She had a risk-benefit discussion with the patient’s son and opted to treat the patient for DVT. (Tr. I-35, 39)

61. Dr. Peters ordered some laboratory tests for the patient. One test was the International Normalized Ratio (INR). (Tr. I-38)

62. An INR’s numerical result reveals how well or poorly a person’s blood can clot. (Tr. I-31, 42, II-87; stipulation)

63. The initial step in an INR is drawing blood from a patient with a finger prick. (Tr. I-42)

64. INR results are quickly available, within minutes of a finger prick. (Tr. II-87)

65. The standard target range for most patients is an INR between 2 and 3. (Tr. I-42-43)[[3]](#footnote-3)

66. An INR between 2 and 3 was the target range for the patient as well. (Tr. I-43)

67. On June 18, 2015, the patient’s INR was 1.0, showing that her blood’s ability to clot was higher than it should have been. (Ex. 9; stipulation)

68. Several factors other than medication may affect a patient’s INR. Diet is one factor. A patient’s eating green leafy vegetables will distort the patient’s INR levels. (Tr. I-171)

69. Dr. Peters prescribed for the patient Lovenox, as a bridge medication, and Coumadin, which is also known as Warfarin. (Ex. 1, p. 52; Tr. I-38, 41)

70. A danger of Coumadin is that it will thin a patient’s blood too much, making it difficult for a patient’s blood to clot and putting the patient at risk of bleeding and losing a large amount of blood. (Tr. I-47-48, II-83)

71. A complication of anticoagulation medication that doctors dread is bleeding in a patient’s brain. (Tr. II-41)

72. Bruising is common with patients who are on anticoagulation medication. (Tr. II-43)

73. Bruising is common in nursing home patients, whether or not they are on anticoagulant medication. (Tr. I-146Tr. II-111, 208)

74. Patients can bruise when they are handled roughly, roll into their side rails, bang into things while in their wheelchairs and during physical therapy, roll over in bed, and roll over on their oxygen tubing. (Tr. I-146-47)

75. On June 18, 2015, Dr. Peters prescribed 2 mg. of Coumadin daily for the patient. (Ex. 1, p. 51; Ex. 9; Tr. I-46; stipulation)

76. Around this time, Dr. Peters ordered that the patient’s INR be checked twice weekly. (Tr. I-46)

77. On June 22, 2015, the patient’s INR was 1.1. (Ex. 1, p. 31; Tr. I-51)

78. Also on June 22, 2015, Dr. Peters changed the Coumadin dose for the patient. On Mondays and Wednesdays, it was 4 mg. daily. It remained 2 mg. daily on other days. (Ex. 1, p. 53; Ex. 9; Tr. I-52)

79. On June 25, 2015, the patient’s INR again was 1.1. (Ex. 1, p. 87; Ex. 9; Tr. I-59; stipulation)

80. Also on June 25, 2015, Dr. Peters changed the Coumadin dose for the patient to 4 mg. daily, every day of the week. (Ex. 1, p. 53; Ex. 9; Tr. I-58; stipulation)

81. On June 29, 2015, the patient’s INR was 1.2. (Ex. 1, p. 88; Ex. 9; Tr. I-66; stipulation)

82. Also on June 29, 2015, in response to the INR, Dr. Peters changed the Coumadin dose for the patient to 5 mg. daily. (Ex. 1, p. 54; Ex. 9; Tr. I-66; stipulation)

83. On July 2, 2015, the patient’s INR was 1.5. (Ex. 1, p. 89; Ex. 9; Tr. I-69) That is, the patient’s blood’s ability to clot was decreasing and slowly approaching the standard range.

84. Also on July 2, 2015, Dr. Peters changed the Coumadin dose for the patient. On Mondays and Wednesdays, it was 7.5 mg. daily. It remained 5 mg. daily on other days. (Ex. 1, p. 59; Ex. 9; Tr. I-69-70; stipulation)

85. Also on July 2, 2015, Dr. Peters prescribed Prednisone to the patient to treat a flare of gout in her right hand. She prescribed 20 mg. orally, daily for five days. (Ex. 1, p. 59; Ex. 9; Tr. I-76-77; stipulation)

86. Prednisone may affect the effectiveness of Coumadin. If a patient on Coumadin receives Prednisone, the hypothetical patient’s INR may increase, decrease – or stay the same. (Tr. I-78, II-66, 303)

87. On July 6, 2015, the patient’s INR increased to 6.4. (Ex. 1, p. 91; Ex. 9; Tr. I-78; stipulation)[[4]](#footnote-4)

88. Also on July 6, 2015, in response to the INR, Dr. Peters ordered the discontinuation of administration of Lovenox to the patient and ordered that administration of Coumadin to the patient be held, that is, suspended, until the patient’s INR was less than 3. (Ex. 1, p. 61; Tr. I-81-82; stipulation)

89. On July 7, 2015, the patient’s INR was 3.5 (Ex. 1, p. 92; Ex. 9; Tr. I-83; stipulation)

90. On July 8, 2015, the patient’s INR was 2.3. (Ex. 1, p. 94; Ex. 9; Tr. I-84; stipulation)

91. Also on July 8, 2015, Dr. Peters prescribed 5 mg. of Coumadin daily for the patient. The patient received 5 mg. of Coumadin daily for the rest of her stay at Heritage Hall West, except for a second time when Dr. Peters ordered that Coumadin be held. (Tr. I-84-85; stipulation)

92. On July 9, 2015, the patient’s INR was 1.9. (Ex. 1, p. 95; Tr. I-89; stipulation)

93. Also on July 9, 2015, Dr. Peters ordered that the patient continue to receive 5 mg. of Coumadin daily and that her INR be checked every Monday and Thursday. (Ex. 1, p. 62; Tr. I- 90)

94. On July 10, 2019, the patient’s INR was 1.9. (Ex. 9)

95. On July 13, 2019, the patient’s INR was 2.1. (Ex. 9; stipulation)

96. On July 16, 2015, the patient’s INR was 2.2. (Ex. 9; stipulation)

97. On July 20, 2015, the patient’s INR was 2.8. (Ex. 9; stipulation)

98. On July 27, 2015, the patient’s INR was 3.0. (Ex. 9; stipulation)

99. On August 3, 2015, the patient’s INR was 4.1. (Ex. 9; Tr. I-109)[[5]](#footnote-5)

100. In response to the patient’s INR and to try to lower it into the therapeutic range, Dr. Peters ordered that Coumadin be held from August 3 through 5, 2015. (Tr. I-100-01; Ex. 9; stipulation)

101. On August 6, 2105, the patient’s INR was 1.7. (Ex. 9; Tr. I-103; stipulation)

102. When the patient again received Coumadin, the dose was 5 mg. per day. (As stated before, that was the dose for the rest of the patient’s stay at Heritage Hall West. (Tr. I-84-85; stipulation))

103. On August 10, 2015, the patient’s INR was 1.8. (Ex. 1, p. 103; Ex. 9; Tr. I-107-08; stipulation)

104. Also on August 10, 2015, Dr. Peters ordered that the patient’s INR be checked on August 17, 2015. (Stipulation)

105. On August 17, 2015, the patient’s INR was 2.5. (Ex. 9; stipulation)

106. Also on August 17, 2015, Dr. Peters determined that that the patient’s INR was stable and it was time to engage in maintenance surveillance, that is, monitoring. She ordered that the patient’s INR be checked again in four weeks, on September 14, 2015. (Ex. 1, p. 74; Tr. I-106, 110-112, 184; stipulation)[[6]](#footnote-6)

107. On August 19, 2015, the patient experienced another flare up of gout. (Tr. I-113)

108. On August 19, 2015, Dr. Peters prescribed another Prednisone burst, a short intense dose, for the gout flare up. On August 20, 2015, the Prednisone burst was administered. (Ex. 1, p. 74; Ex. 9; Tr. I-113-14, 119; stipulation)[[7]](#footnote-7)

109. Dr. Peters did not order any immediate change in Coumadin for the patient and did not order additional INR monitoring. (Tr. I-120)

110. On August 20, 2015, Dr. Peters ordered that the patient’s Coumadin be discontinued on September 16, 2015 and that the INR test, scheduled for September 14, 2015, be canceled. (Tr. I-75)

111. Three months of Coumadin is the recommended course for DVT (Tr. II-190), and by September 16, 2015, the patient’s three-month course would be over.

112. On August 27, 2015, an employee at Heritage Hall West called Dr. Peters to report that the patient had a new bruise on her right mid-back, about 3.8 cm by 8 cm. (Ex. 1, p. 131; Tr. I-122; stipulation)

113. The employee told Dr. Peters that the patient had not fallen or experienced any trauma. (Tr. I-122)

114. Dr. Peters ordered the nursing staff to continue to observe the patient’s bruise. (Ex. 1, p. 131;Tr. I-122)

115. Also on August 27, 2015, Dr. Peters received a second telephone call from an employee at Heritage Hall West, reporting that the patient had a second bruise, this one 0.5 cm by 0.5 cm and red on her lower eyelid. (Ex. 1, p. 131; stipulation)[[8]](#footnote-8)

116. Dr. Peters again ordered the nursing staff to continue to monitor the patient’s bruise. (Ex. 1, p. 131; stipulation)[[9]](#footnote-9)

117. The previous order was the last one that Dr. Peters gave to direct care for the patient. (Tr. I-135-36)

118. On August 27, 2015, the patient’s bruise involved her hip, flank, and buttock. (Tr. II-87-88; *see* Ex. 1, p. 130)

119. On August 30, 2015, a nurse practitioner ordered that the patient’s INR level be checked the next morning. (Ex. 1, p. 77; Tr. II-89)

120. On August 30, 2015, before her INR level could be checked at Heritage Hall West, the patient was transported to Mercy Medical Center, in Springfield. (Ex. 2, p. 6; Tr. II-91)

121. On August 30, 2015, the patient’s INR was 17.36. (Ex. 2, p. 16; Tr. II-91)

122. An INR that high is a medical emergency; the risk of spontaneous bleeding was very high. (Tr. II-91)

123. To lower her INR, the patient received vitamin K intravenously and three bags of fresh frozen plasma, the component of blood that contains clotting factors, which she lacked. (Tr. II-94)

124. The patient died on August 31, 2015. (Ex. 2, p. 43)

125. The patient’s death certificate reads:

Immediate cause (Final condition resulting in death): acute myocardial infarction Due to or as a consequence of cardiogenic shock

Due to or as a consequence of blood loss anemia

Due to or as a consequence of hematoma.

(Ex. 10) (some all-capitals reduced to lower case)[[10]](#footnote-10)

126. On December 17, 2018, Dr. Peters wrote to the Board of Registration in Medicine in part:

I do wish in retrospect I had obtained an INR after the second course of prednisone as it would have been a reasonable [sic][[11]](#footnote-11) to do so.[[12]](#footnote-12)

….

…I did not check her INR this time around [after the second Prednisone burst] as I felt in my judgment *at the time* that it was not necessary.

(Ex. 8) (emphasis added).

127. On March 26, 2018, Dr. Peters wrote to a BRM investigator about the possibility of the patient’s having had a DVT:

The definitive test was a dye study at a hospital, which I do not think she [the patient] could tolerate based on renal function.

(Ex. 7)

128. On July 16, 2020, BRM filed a Statement of Allegations against Dr. Peters. (Statement of Allegations)

129. According to the Statement of Allegations, Dr. Peters “practiced medicine in violation of law, regulations, or good and accepted medical practice….”[[13]](#footnote-13)

130. According to the Statement of Allegations, Dr. Peters’s treatment of the patient fell beneath the applicable standard of care for three reasons:

1. “[S]he failed to properly work up Patient MD’s leg edema before diagnosing… her with a DVT and prescribing Coumadin.”

2. “[S]he failed to adequately monitor Patient MD’s INR level, including but not limited to after initiating a Prednisone regimen on August 19, 2015.”[[14]](#footnote-14)

3. “[S]he failed to properly follow-up on Patient MD’s bruising although bruising is a clear warning of dangerous bleeding in patients receiving Coumadin and/or other anti-coagulants.”[[15]](#footnote-15)

131. The Statement of Allegations stated four legal bases for proposed relief:[[16]](#footnote-16)

A. Pursuant to Mass. Gen. Laws c. 112, §5, eighth 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 said physician 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 Mass. Gen. Laws c. 112, § 61.

C. Pursuant to 243 CMR 1.03(5)(a)(18), the Board may discipline a physician upon proof satisfactory to a majority of the Board that said physician has engaged in misconduct in the practice of medicine.

D. Pursuant to *Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1979) and *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.

**Discussion**

Overview

My reading of the Statement of Allegations leads me to understand that my task is to determine (1) whether Dr. Peters practiced medicine below the standard of care; and (2) whether the substandard care constituted conduct that places into question her competence to practice medicine, such as gross misconduct, gross incompetence, gross negligence, or repeated negligence; malpractice; misconduct; or conduct that undermines the public confidence in the integrity of the medical profession.

Before so determining, I examine a preliminary issue and various definitions.

BRM’s expert was not a geriatrician

At and after the hearing, Dr. Peters objected strenuously and repeatedly that BRM’s expert, Dr. Nowak, is not a geriatrician, as she is, but rather, a palliative care specialist. However, Dr. Peters did not explain why the appellate opinions on this issue do not govern:

A medical expert need not be a specialist in the area concerned nor be practicing in the same field as the defendant. It is well established that the professional specialty of a medical practitioner offered as a witness need not be precisely and narrowly related to the medical issues of the case. Thus, it has been held that a judge, in his discretion, properly admitted the opinions of a general practitioner in a case which related to specialized medical issues.

*Letch v. Daniels*, 401 Mass. 65, 68 (1987) (quotation marks and citations omitted). “It was not necessary for the plaintiff’s medical expert to be a specialist in the area concerned.” *Gill v. Northshore Radiological Associates, Inc.*, 10 Mass. App. Ct. 885, 885 (1980).

The crucial issue is whether the witness has sufficient education, training, experience and familiarity with the subject matter of the testimony.

*Letch*, 401 Mass. at 68 (quotation marks and citations omitted). Dr. Nowak satisfied those characteristics.

Jury instructions for medical malpractice state, “An expert …does not have to be a specialist in [the defendant’s] are of practice.” Superior Court Model Jury Instructions, https://www.mass.gov/guides/superior-court-model-jury-instructions#-civil-instructions (May 25, 2021) (citing *Letch*).

Standard of care

“A physician is held to the standard of care and skill of the average member of the medical profession practicing his specialty at the time of the alleged negligence.”

*Palandjian v. Foster*, 446 Mass. 100, 112 (2006) (citations, quotation marks, and emphases omitted). *See also* Tr. II-25.

Negligence

For a doctor to provide medical care below the standard of care constitutes negligence. *Palandjian*, 446 Mass. at 112; Superior Court Model Jury Instruction for medical malpractice.

Conduct that places into question doctor’s competence to practice medicine, such as gross misconduct[[17]](#footnote-17)

“‘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. ‘Gross’ is generally defined as ‘flagrant’ and ‘extreme.’” *State ex rel. Gremillion v. O’Hara*, 252 La. 540, 552, 211 So.2d 641 (1968). Webster’s New International Dictionary 1106 (2d ed. 1959), defines “gross” in part to mean “[o]ut of all measure; beyond allowance; not to be excused; flagrant; shameful; as, a gross injustice.”

*Hellman v. Board of Registration in Medicine*, 404 Mass. 800, 804 (1989).

Conduct that places into question doctor’s competence to practice medicine, such as gross incompetence

The parties did not brief what it means for a doctor to have engaged in gross incompetence. When I asked them for definitions or illustrative cases, they did not provide any. I have been unable to locate a definition in Massachusetts of gross incompetence. The Nebraska Supreme Court stated that

“gross incompetence,” at least in the context of the practice of medicine… connotes such an extreme deficiency on the part of a physician in the basic knowledge and skill necessary for diagnosis and treatment that one may reasonably question his or her ability to practice medicine at the threshold level of professional competence.

*Langvardt v. Horton*, 254 Neb. 878, 895, 581 N.W.2d 60, 70–71 (1998) (citing cases from the 9th Circuit, California, Colorado, New Jersey, and Oregon).

General Laws c. 112, §5, eighth par. (c) and 243 CMR 1.03(5)(a)(3) subject doctors to discipline for conduct, *such as* gross incompetence, that places into question a doctor’s competence to practice medicine. The Nebraska Supreme Court’s definition, which I accept, means that gross incompetence *as an example* of what it means for a doctor to practice medicine so as to place their competence into question does not add much. Gross incompetence *is* practicing medicine in a way that places a doctor’s competence into question.

Conduct that places into question doctor’s competence to practice medicine, such as gross negligence

Gross negligence is substantially and appreciably higher in magnitude than ordinary negligence. It is materially more want of care than constitutes simple inadvertence. 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 very great negligence….It amounts to indifference to present legal duty and to utter forgetfulness of legal obligations so far as other persons may be affected. It is a heedless and palpable violation of legal duty respecting the rights of others. The element of culpability which characterizes all negligence is in gross negligence magnified to a high degree as compared with that present in ordinary negligence. Gross negligence is a manifestly smaller amount of watchfulness and circumspection than the circumstances require of a person of ordinary prudence….Ordinary and gross negligence differ in degree of inattention….This definition does not possess the exactness of a mathematical demonstration, but it is what the law now affords.

*Altman v. Aronson*, 231 Mass. 588, 591–92 (1919) (quoted extensively in *Hellman v. Bd. of Registration in Medicine,* 404 Mass. 800, 804 (1989)). Repeated negligence can double as gross negligence; repeated failure to act on warning signs may constitute gross negligence. *Board of Registration v. Suzanne B. Rothchild, M.D.*, RM-06-241, RM-08-28, RM-08-157 \*11 (2013).

Conduct that places in question doctor’s competence to practice medicine, such as repeated negligence

I have already defined negligence. Conduct that would constitute repeated negligence in this case is fairly obvious.

Malpractice

A doctor commits malpractice when the doctor was negligent, and the negligence caused injury to the patient. *Doherty v. Hellman*, 406 Mass. 330, 336 (1989).

Generally, a defendant is a factual cause of a harm if the harm would not have occurred “but for” the defendant's negligent conduct. See W.L. Prosser & W.P. Keeton, Torts § 41, at 265 (5th ed. 1984) (“An act or an omission is not regarded as a cause of an event if the particular event would have occurred without it”). See, e.g., Hollidge v. Duncan, 199 Mass. 121, 124, 85 N.E. 186 (1908) (affirming determination that plaintiff's injuries would not have occurred “but for the defendant's negligence”). See also Reporters’ Note to Restatement (Third) § 26 comment b (collecting authorities demonstrating that “but-for test is central to determining factual cause”)…. Another way to think about the but-for standard is as one of necessity; the question is whether the defendant's conduct was necessary to bringing about the harm. Restatement (Third) § 26 comment b (“a factual cause can also be described as a necessary condition for the outcome”).

*Doull v. Foster*, 487 Mass. 1, 7–8 (2021). “The focus…remains only on whether, in the absence of a defendant's conduct, the harm still would have occurred.” *Id.* at 12–13 (citation omitted).

Misconduct

As noted above,

“‘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.

*Hellman*, 404 Mass. at 804.

Conduct that undermines the public confidence in the integrity of the medical profession

Apparently, no definition exists of conduct that undermines the public confidence in the integrity of the medical profession. In the Statement of Allegations, BRM cited two cases, *Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1979) and *Raymond v. Board of Registration in Medicine*, 387 Mass. 708 (1982), and I take them as illustrative cases of this ground for discipline. In *Levy*, the doctor was convicted of “serious criminal offenses” related to the practice of medicine. 378 Mass. at 520. In *Raymond*, the doctor was convicted of crimes unrelated to the practice of medicine, namely, firearms crimes. 387 Mass. at 709-10.

In *Board of Registration in Medicine v. Heidi Ashih*, M.D., RM-16-67 (DALA 2016) (Bresler, A.M.), a psychiatrist engaged in conduct that undermines the public confidence in the integrity of the medical profession by having a patient live and vacation with her family.

First allegation: Dr. Peters failed to properly work up the patient’s leg edema before diagnosing her with a DVT and prescribing Coumadin

According to the Statement of Allegations, Dr. Peters’s failure to properly work up the patient’s leg edema before diagnosing her with a DVT and prescribing Coumadin fell beneath the standard of care.

On June 15, 2015, Dr. Peters evaluated the patient for edema in her leg. (Ex. 1, p. 31; Tr. I-31; stipulation) Around then, Dr. Peters examined the patient and considered the examination to be “grossly positive” for DVT. (Tr. I-35) Also around then, she used the Wells Criteria and derived a score for the patient between 2 and 4, which indicated a moderate probability that the patient had a DVT. (Tr. II-61) On June 17, 2015, Dr. Peters ordered an ultrasound and a D-Dimer test for the patient. (Ex. 1, p. 52; Tr. I-33-34; stipulation) The ultrasound was negative for DVT. (Tr. I-34) The D-Dimer test left open the possibility that the patient had a DVT. (Tr. I-34)

A patient’s DVT is dangerous; it can lead to a fatal pulmonary embolism. (Tr. I-119, 120, 149) Treating a patient’s DVT with Coumadin carries risks; a patient can bleed excessively, especially in the brain, and lose a large amount of blood. (Tr. I-47-48, II-83) Dr. Zizza noted that when treating patients, doctors need to balance the risk of patients’ getting clots versus their risk of bleeding. (Tr. II-121) On one side of the balance for this particular patient, Dr. Zizza opined that it would be very rare for a 93-year-old with dementia to survive a pulmonary embolism. (Tr. II-304) On the other side of the balance for this patient, Dr. Nowak opined that the patient should not have received Coumadin without a more definite diagnosis of DVT because her age alone increased her bleeding risk, she was on multiple medications, she had impaired cognition, strength, and balance, and she had a tendency to faint. Some of those factors put her at risk of falling, which would have bruised the patient, putting her at further risk. (Tr. II-56-57)

Dr. Peters weighed the respective risks and the likelihood that the patient had a DVT.

She decided that she “would rather treat” what she believed was a DVT. She consulted with the patient’s son, who was the patient’s health care proxy and who agreed with Dr. Peters’s plan. (Ex. 1, p. 31)

In its brief, BRM argued that Dr. Peters misdiagnosed the patient as having a DVT. I have no evidence before me that the patient did not have a DVT. In fact, Dr. Zizza opined that with the patient’s symptoms, the likelihood that she had a DVT or a similar condition was 80 to 90%. (Tr. II-247)

In its brief, BRM argued that even if the patient had a DVT, it was in her calf veins, and the probability that it would have led to a pulmonary embolism was “decidedly lower” than if it had been in her thigh veins. An argument based on a “decidedly lower” probability is too nebulous for me to find substandard care in this circumstance. The rest of BRM’s arguments about Dr. Peters’s prescribing Coumadin for the patient are uncompelling.

Dr. Nowak opined that Dr. Peters should not have prescribed Coumadin for the patient after the ultrasound was negative because of the risks to the patient. She opined that for Dr. Peters to have prescribed Coumadin was beneath the standard of care. (Tr. II-56-57) As for what Dr. Peters should have done, Dr. Nowak opined that if Dr. Peters was still concerned about a DVT, she should have repeated the ultrasound five to seven days later. (Tr. II-59) (Dr. Peters has explained why she did not order a dye study at a hospital (Ex. 7), but BRM has not alleged that she should have ordered such a study.) Dr. Zizza opined that Dr. Peters’s treating the patient for a DVT and not treating her for a DVT would have been within the standard of care for an average geriatrician in 2015. (Tr. II-224-25, 226, 248, 249, 317)

The BRM has the burden of proof, *see* *Sheldon Randall, M.D. v. Board of Registration in Medicine*, SJ-2014-0475 (single-justice decision, June 9, 2015); *Board of Registration in Medicine v. Hans Agrawal, M.D.*, RM-14-9 (DALA April 4, 2016), by a preponderance of the evidence, *Agrawal*, that it was beneath the standard of carefor Dr. Peters to treat the patient for a DVT with Coumadin.

The preponderance of the evidence slightly favors Dr. Peters for two reasons. One, I found Dr. Nowak and Dr. Zizza both to be credible experts. They were knowledgeable, experienced, authoritative, and candid. Their opinions balance each other. With this factor alone, the preponderance of the evidence would favor neither party, and BRM would not have proved its position by a preponderance of the evidence. Two, I may and do accept the expert opinion of Dr. Nowak, a palliative care specialist, about geriatricians’ standard of care and whether Dr. Peters provided it. However, the expert opinion of Dr. Zizza is slightly more authoritative about geriatricians’ standard of care and whether Dr. Peters provided it, because he is a geriatrician. Dr. Zizza’s slightly more authoritative opinion tilts the preponderance of the evidence against BRM.

I do not find that Dr. Peters practiced medicine beneath the standard of care for failing to properly work up the patient’s leg edema before diagnosing her with a DVT and prescribing Coumadin. Because I do not find that Dr. Peters provided substandard care in this regard, I need not and do not examine whether her treatment of the patient in this regard constituted conduct that places into question her competence to practice medicine, such as gross misconduct, gross incompetence, gross negligence, or repeated negligence; malpractice; misconduct; or conduct that undermines the public confidence in the integrity of the medical profession.

Second allegation: Dr. Peters failed to adequately monitor the patient’s INR level, including but not limited to after initiating a Prednisone regimen on August 19, 2015

According to the Statement of Allegations, Dr. Peters’s failure to adequately monitor the patient’s INR level, including but not limited to after initiating a Prednisone regimen on August 19, 2015, fell beneath the standard of care.

On July 2, 2015, when the patient’s INR was 1.5 (Ex. 1, p. 89; Ex. 9; Tr. I-69), Dr. Peters did two things. One, she increased the patient’s Coumadin dose from 5.0 mg. every day to 5.0 mg. daily on five days per week and 7.5 mg. daily on two days per week. Two, she prescribed a Prednisone burst. (Ex. 1, p. 59; Ex. 9; Tr. I-69-70, 76-77; stipulation)

On July 6, 2015, the patient’s INR increased from 1.5, below the standard range, to 6.4, above the standard range. (Ex. 1, p. 91; Ex. 9; Tr. I-78; stipulation) Dr. Peters’s position is that the patient’s INR increased in response to the increased Coumadin dose. BRM’s position is that whether the patient’s INR rose in response to the increased Coumadin dose or the Prednisone is unknown. (Tr. I-78-81, 102, 159-60, II-67)

On August 17, 2015, the patient’s INR was 2.5. (Ex. 9; stipulation) On the same date, Dr. Peters determined that the patient’s INR was stable and it was time to engage in maintenance surveillance. She ordered that the patient’s INR be checked again in four weeks, on September 14, 2015. (Ex. 1, p. 74; Tr. I-106, 110-112, 184; stipulation)

On August 19, 2015, Dr. Peters prescribed another Prednisone burst, which the patient received on August 20, 2015. (Ex. 1, p. 74; Ex. 9; Tr. I-113-14, 119; stipulation) Dr. Peters did not order an INR to follow the Prednisone burst. (Tr. I-120)

BRM faults Dr. Peters for these August events in two ways. One, BRM alleges that Dr. Peters should have known in August 2015 that the patient’s INR might increase after the Prednisone, as it had done in July 2015. Therefore, Dr. Peters should have ordered an INR test. Two, BRM alleges that the patient’s INR was not stable enough to put off testing it for four weeks. I will discuss the first ground now and then the second ground.

Neither party’s position on the first ground is strong. BRM’s position is *not* that Prednisone definitely increased the patient’s INR. BRM’s position is that it is unknown whether the Prednisone burst or the higher Coumadin dose increased the patient’s INR in July 2021. BRM acknowledges that the higher *Coumadin* dose, and not the Prednisone, might have increased the patient’s INR in July 2021. *See* BRM Br. 17-18 (“[I]t was impossible to determine which medication caused the elevation. Therefore, the Respondent deviated from the…standard of care by failing to exercise due caution” when prescribing Prednisone, “especially since she knew or should have known…that it *may* have been problematic” for the patient) (emphasis added).

As for Dr. Peters, her position is not strong because she expressed regret for not having ordered an INR test after ordering the second Prednisone burst. (Ex. 8)

Dr. Nowak, BRM’s expert, opined that Dr. Peters’s failure to order an INR test after this second Prednisone burst was below the standard of care. (Tr. II-81, 100-01, 174) Dr. Zizza did not opine on this issue. Thus, BRM has proved by a preponderance of the evidence that Dr. Peters’s failure to order an INR test after this second Prednisone burst was below the standard of care.

I now examine whether Dr. Peters’s substandard care of the patient in this regard constituted conduct that places into question her competence to practice medicine, such as gross misconduct, gross incompetence, gross negligence, or repeated negligence; malpractice; misconduct; or conduct that undermines the public confidence in the integrity of the medical profession.

Dr. Peters explained why she thought that the higher Coumadin dose, rather than the Prednisone burst, increased the patient’s INR to 6.4 on July 6, 2015: She expected to see the patient’s INR increase three to five days after the higher Coumadin dose, given on July 2, 2015; the INR increased on July 6, four days later. In addition, the patient’s INR dropped precipitously to 3.5 on July 7, 2015 and 2.3 on July 8, 2015, while the patient was still on Prednisone. Therefore, she believed that the Prednisone was not responsible for the patient’s INR of 6.5 on July 6, 2015. (Tr. I-159-60) Dr. Peters was not clearly wrong and BRM has not alleged that she was clearly wrong. BRM alleges that she might have been wrong.

Misconduct and conduct that places into question her competence to practice medicine, such as gross misconduct

Dr. Peters, in not ordering an INR after the second Prednisone burst, did not engage in

“intentional wrongdoing or lack of concern for [her] conduct.” *Hellman* 404 Mass. at 804. Therefore, she did not engage in misconduct. If she did not engage in misconduct, she could not have engaged in gross misconduct, even if the consequence, the patient’s death, was a gross consequence.

Conduct that places into question her competence to practice medicine, such as gross negligence

Dr. Peters, in not ordering an INR after the second Prednisone burst, practiced medicine below the standard of care and, by definition, was negligent. However, Dr. Peters’s negligence was not “very great negligence” or “negligence magnified to a high degree….” *Altman*, 231 Mass. at 591. It was not “a heedless and palpable violation of legal duty respecting the rights” of the patient. She did not exhibit “indifference to present legal duty” or “utter forgetfulness of legal obligations” to the patient. *Id.* at 591. Therefore, she did not commit gross negligence, even though her negligence had a gross consequence, the patient’s death.

Conduct that places into question her competence to practice medicine, such as repeated negligence

Dr. Peters’s negligence was not repeated; she was negligent once.

Conduct that places into question her competence to practice medicine, such as gross incompetence

Of the four examples of conduct that places into question a doctor’s competence to practice medicine, three do not apply here: gross misconduct, gross negligence, and repeated negligence. The fourth example, gross incompetence, is practically a synonym for conduct that places into question a doctor’s competence to practice medicine. *Langvardt*, 254 Neb. at 895, 581 N.W.2d at 70–71. As I see it, the issue for purposes of discussing Dr. Peters’s competence is not that Dr. Peters failed to order an INR after ordering a second Prednisone burst. As I see it, the issue is that Dr. Peters believed that the patient’s INR increase in July 2015 was due to the higher Coumadin dose and not the Prednisone. Dr. Peters was not clearly wrong, BRM has not proven that she was clearly wrong, and BRM does not even allege that she was clearly wrong; BRM’s position is that the Coumadin *or* the Prednisone could have caused the increase in INR. Dr. Peters’s belief is not an example of medical incompetence.

Conduct that places into question her competence to practice medicine

By not ordering an INR after the second Prednisone burst, Dr. Peters did not engage in any of the four examples of conduct that places into question a doctor’s competence to practice medicine. BRM did not prove that she engaged in conduct that places into question her competence to practice medicine. Again, BRM does not even allege that Dr. Peters was clearly wrong in identifying the higher Coumadin dose and not the Prednisone as the reason why the patient’s INR increased in July 2015.

Malpractice

For our purposes, malpractice has two elements: negligence and resulting injury to a patient. *Doherty*, 406 Mass. at 336. The element of negligence is present; Dr. Peters practiced medicine beneath the standard of care by not ordering an INR test after the second Prednisone burst. Resulting injury is present: The patient died.

Dr. Nowak opined that the patient’s

cause of death was enumerated cardiogenic shock, multiorgan system failure from a myocardial infarction that was precipitated by a critically low blood count due to severe hemorrhage because of a supratherapeutic INR in the context of Coumadin therapy.

(Tr. II-98) (Supratherapeutic means above the therapeutic level.)

More specifically, Dr. Nowak opined that the patient was being treated at Mercy Medical Center for

cardiogenic shock with medications to support her blood pressure because her blood pressure was critically low, such that vital organs were not being perfused, not seeing vital blood flow with oxygen, in the face of a massive heart attack, that was precipitated by severe hemorrhage in which her blood count dropped from a normal level to a critically low level, which was precipitated by hemorrhaging from an INR that was critically high, not slightly high, critically high, 17.36, due to Coumadin therapy.

(Tr. II-95-96)

But did the failure to order an INR test – the negligence – injure the patient? Or did a dangerously high INR injure the patient, a high INR that Dr. Peters’s failure to order an INR test left undetected?

When questioned about causation more closely, Dr. Nowak opined that had medical personnel discovered that the patient’s INR was so high, they *may* have been able to prevent her death. (Tr. II-171) Dr. Peters’s failure to order a test did not cause the patient’s death but had she ordered a test, the test might have saved the patient. (Tr. II-173) Dr. Nowak could not specify within a reasonable degree of medical certainty that if Dr. Peters had ordered a test, it would have changed the outcome, namely, the patient’s death. (Tr. II-173)

During the hearing, through objections and cross-examination of Dr. Nowak, Dr. Peters emphasized the “but-for” standard of causation in *Doull*. However, Dr. Peters did not directly brief the issue of whether she had committed medical malpractice. During the hearing, she appeared to develop an argument that she did not later brief: her failure to order a test did not proximately cause the patient’s death.

Our courts have assumed that a doctor’s failure to order a test can constitute medical malpractice. *See Kace v. Liang*, 472 Mass. 630, 634 (2015); *Goudreault v. Nine*, 87 Mass. App. Ct. 304, 310 (2015); *Bing v. Drexler*, 69 Mass. App. Ct. 186, 188 (2007); *Rahilly v. N. Adams Regional Hospital*, 36 Mass. App. Ct. 714, 718 (1994); *LaFond v. Casey*, 43 Mass. App. Ct. 233, 234 (1997); *Cusher v. Turner*, 22 Mass. App. Ct. 491, 498 (1986). The courts have so assumed even though a test is not a treatment.

Dr. Peters committed medical malpractice when she failed to order an INR test for the patient after the patient’s Prednisone burst in August 2015.

Conduct that undermines the public confidence in the integrity of the medical profession

BRM did not brief this issue. Dr. Peters discussed it in a footnote in her post-hearing brief, noting that Dr. Peters was not charged with conduct remotely analogous to the doctors’ conduct in *Levy* or *Raymond*. I find that Dr. Peters’s conduct related to the medical profession, but not the *integrity* of the medical profession.

As for public confidence in the integrity of the medical profession, I have to put myself in the place of typical members of the public and gauge their reaction to learning what I learned. I surmise that typical members would be critical of Dr. Peters’s decision not to order an INR test after the second Prednisone burst, but would not lose confidence in the integrity of the medical profession. I find that Dr. Peters did not undermine the public confidence in the integrity of the medical profession.

I now discuss the second ground of the second allegation in the Statement of Allegations, that the patient’s INR was not stable enough for Dr. Peters to have ordered that she not be tested for four weeks.

Dr. Nowak, BRM’s expert, opined that the patient’s INR was not stable enough for the INR testing schedule that Dr. Peters established. (Tr. II-35, 76) She opined that Dr. Peters’s decision to discontinue regular monitoring was substandard care. (Tr. II-77)

Dr. Zizza, Dr. Peters’s expert, disagreed. He opined the following: Two or three INR tests can indicate stability. (Tr. II-272, 308-09) Three INR tests indicated that the patient had reached stability (Tr. II-308), referring to July 13 (2.1), July 16 (2.2), and July 20 (2.8), 2015. (Tr. II-252, Ex. 9). If one extrapolates from the three tests, it was unthinkable that the patient’s INR would reach 17 (Tr. II-252), as it did. (Ex. 2, p. 16)

Dr. Zizza further opined the following: Even though the patient’s INR was stable, keeping a geriatric patient within the standard range of INR is difficult. If a patient is within the standard range 60% of the time, geriatricians consider it successful. (Tr. II- 228) It was within the standard of care for Dr. Peters to order on August 17, 2015 that the patient’s INR next be tested on September 14, 2015. (Tr. II-252)

The BRM has the burden of proving this allegation by a preponderance of the evidence. *See Agrawal*. As I wrote above, the preponderance of the evidence slightly favors Dr. Peters for two reasons. One, while Dr. Nowak and Dr. Zizza are both credible experts, their opinions balance each other out. Two, the expert opinion of Dr. Zizza is slightly more authoritative about geriatricians’ standard of care because he is a geriatrician. That tilts the preponderance of the evidence against BRM.

I do not find that Dr. Peters practiced medicine beneath the standard of care for ordering in August 2015 that the patient’s next INR test be in four weeks. Because I do not find that Dr. Peters provided substandard care in this regard, I need not and do not examine whether her treatment of the patient in this regard constituted conduct that places into question her competence to practice medicine, such as gross misconduct, gross incompetence, gross negligence, or repeated negligence; malpractice; misconduct; or conduct that undermines the public confidence in the integrity of the medical profession.

Third allegation: Dr. Peters failed to properly follow up on the patient’s bruising

According to the Statement of Allegations, Dr. Peters’s failure to properly follow up on the patient’s bruising fell beneath the standard of care. As I noted above, BRM was not explicit in the Statement of Allegations or in the hearing about how Dr. Peters could or should have followed up. Strictly speaking, Dr. Peters did follow up on the patient’s bruising. Twice on August 27, 2015, Dr. Peters ordered the nursing staff to continue to observe the patient’s bruises. (Ex. 1, p. 131;Tr. I-122; stipulation) She did not ignore the two reports of the patient’s bruises. However, because Dr. Nowak, BRM’s expert, opined that Dr. Peters should have immediately ordered an INR test (Tr. II-86), I assume that that is the followup that BRM alleges Dr. Peters should have done.

Dr. Zizza, Dr. Peters’s expert, opined that for a doctor to have monitored the bruises without ordering an INR test was within the standard of care, although ordering an INR would have been within the standard of care too. (Tr. II-262-63, 311, 317) I take his testimony to mean that ordering an INR test after the patient’s bruising appeared would have been within the standard of care, but that the standard of care did not *require* that Dr. Peters have ordered an INR test.

The BRM has the burden of proving this allegation by a preponderance of the evidence. *See Agrawal*. Again, the preponderance of the evidence slightly favors Dr. Peters for two reasons. One, while Dr. Nowak and Dr. Zizza are both credible experts, their opinions balance each other out. Two, the expert opinion of Dr. Zizza is slightly more authoritative about geriatricians’ standard of care because he is a geriatrician. That tilts the preponderance of the evidence against BRM.

I do not find that Dr. Peters practiced medicine beneath the standard of care for not ordering an INR test for the patient after she developed bruises. Because I do not find that Dr. Peters provided substandard care in this regard, I need not and do not examine whether her treatment of the patient in this regard constituted conduct that places into question her competence to practice medicine, such as gross misconduct, gross incompetence, gross negligence, or repeated negligence; malpractice; misconduct; or conduct that undermines the public confidence in the integrity of the medical profession.

**Conclusion and Order**

I find that one omission by Dr. Peters was beneath the standard of care: She failed to order an INR test in August 2015 for the patient after the patient received her second Prednisone burst. I find that the omission constituted one instance of malpractice by Dr. Peters. I recommend that BRM discipline her as appropriate.

I find that other acts and omissions by Dr. Peters were not beneath the standard of care. I recommend that BRM not discipline her for them. I find that Dr. Peters did not engage in conduct that places into question her competence to practice medicine, such as gross misconduct, gross incompetence, gross negligence, or repeated negligence; misconduct; conduct that undermines the public confidence in the integrity of the medical profession; or, except for one instance, malpractice.

DIVISION OF ADMINISTRATIVE LAW APPEALS

Signed by Kenneth Bresler, M.D.

Kenneth Bresler

Administrative Magistrate

Dated: SEP 30 2021

1. The medical records indicate that the patient had a problem with her right leg, Ex. 1, p. 31, but that was a typographical error. (Tr. I-48-50) [↑](#footnote-ref-1)
2. Dr. Nowak, BRM’s expert, opined that Dr. Peters should not have prescribed Coumadin for the patient after this negative result for DVT. (Tr. II-56, 131) The fact that Dr. Peters did prescribe Coumadin is one basis for the complaint against Dr. Peters. Dr. Nowak also opined that if Dr. Peters was still concerned about a DVT, she should have repeated the ultrasound five to seven days later. (Tr. II-59) Dr. Zizza opined that for Dr. Peters to have either treated the patient as if she had a DVT or as if she did not have a DVT would have been within the standard of care. (Tr. II-224-25, 226, 248, 249) [↑](#footnote-ref-2)
3. Dr. Peters also testified that geriatricians accept “reasonable proximity” to the target range and that for a frail, elderly 93-year-old patient, 1.7 to 3.2 was “reasonably close to the textbook therapeutic range” and a “reasonable range for someone in this age group.” (Tr. 103-06) [↑](#footnote-ref-3)
4. During the hearing, Dr. Peters attributed this increase of INR to the 7.5 mg. of Coumadin that she had prescribed twice weekly. She disagreed with BRM’s Complaint Counsel’s question that it was unclear whether the increase in INR was due to the increased Coumadin or the Prednisone. (Tr. I-78-81, 102, 159-60) Dr. Nowak opined that the patient’s raised INR score of 6.4 on July 6, 2015 could not be attributed definitely to the Prednisone or increased dose of Coumadin. (Tr. II-67) [↑](#footnote-ref-4)
5. Dr. Nowak, BRM’s expert, opined that after this INR result, Dr. Peters should have monitored the patient’s INR more frequently. (Tr. II-71, 101) The fact that Dr. Peters did not do so is one basis for the complaint against Dr. Peters. [↑](#footnote-ref-5)
6. Dr. Nowak, BRM’s expert, opined that the patient’s INR was not stable enough for the INR testing schedule that Dr. Peters established. (Tr. II-35, 76, 164) She opined that Dr. Peters’s decision to discontinue regular monitoring was substandard care. (Tr. II-77) Dr. Zizza, Dr. Peters’s expert, opined that Dr. Peters’s decision was within the standard of care. (Tr. II-252) [↑](#footnote-ref-6)
7. Dr. Nowak, BRM’s expert, opined that Dr. Peters’s failure to order an INR test after this second Prednisone burst was below standard of care. (Tr. II-81, 100-01) [↑](#footnote-ref-7)
8. Dr. Zizza, Dr. Peters’s expert, did not consider either bruise to be major. (Tr. II-258) [↑](#footnote-ref-8)
9. Dr. Nowak, BRM’s expert, opined that a patient’s unexplained bruising in the absence of trauma and while receiving blood thinners may indicate spontaneous bleeding, a complication of Coumadin, and should signal a doctor to conduct INR tests more aggressively. (Tr. II-83) She opined that Dr. Peters’s failure to immediately order an INR test in response to the reports of bruising was below the standard of care. (Tr. II-86) Dr. Zizza, Dr. Peters’s expert, opined that for a doctor to have monitored the bruises without ordering an INR test was within the standard of care, although ordering an INR would have been within the standard of care too. (Tr. II-262-63, 311, 317) [↑](#footnote-ref-9)
10. Dr. Nowak opined that the patient’s critically high INR of 17.36 caused hemorrhaging, a critically low blood count, not enough blood to carry oxygen, resulting in a massive heart attack. (Tr. II-95-96) [↑](#footnote-ref-10)
11. Dr. Peters presumably meant that “it would have been reasonable” or it would have been a reasonable” [fill in a noun, such as “thing” or “course of treatment”]. [↑](#footnote-ref-11)
12. This statement was the subject of an unusual part of the examination during the hearing. The Board of Registration in Medicine’s complaint counsel asked Dr. Peters whether she had considered whether it would have been reasonable for her to order an INR around the time that she ordered Prednisone from August 20 to 24, 2015. Dr. Peters answered no. Complaint counsel asked again, and Dr. Peters answered, “No, because I knew what her [the patient’s] previous reaction [to Prednisone] was.” (Tr. I-136) Complaint counsel then brought the statement in her letter of December 17, 2018 to Dr. Peters’s attention. Dr. Peters stated that her not ordering an INR did not violate the standard of care; it was reasonable not to have ordered it and it would have been reasonable had she ordered it. (Tr. I-136-37)

    The subject of Dr. Peters’s testimony was not apparently what complaint counsel was focusing on. Complaint counsel was apparently focusing on the first part of Dr. Peters’s statement, “I do wish in retrospect I had obtained an INR after the second course of prednisone….” Dr. Peters was focusing on the second part of her statement: “as it would have been…reasonable to do so.” Dr. Peters was apparently striving to argue her case, namely, that she had not violated the standard of care and that she had acted reasonably.

    Complaint counsel then asked, invoking a common-sense reading of Dr. Peters’s statement in her letter, asked, “[Y]ou said: Knowing what you know now, you might’ve ordered it?” Dr. Peters declined to answer directly, in effect repeating her written statement in Exhibit 8: “In retrospect, I think it would have been reasonable to do so.” (Tr. I-137) *See* Tr. I-139 (Dr. Peters’s repeated her position that “had I known what I know now…I think it would have been reasonable” to have monitored the patient’s INR).

    Complaint counsel asked a follow-up question that did not seek information protected by attorney-client privilege or approached seeking it, as far as I could discern. Dr. Peters’s lawyer, in a near-*non sequitur*, cautioned Dr. Peters not to discuss information protected by attorney-client privilege. (Tr. I-137)

    The way that the examination unfolded was not its only unusual aspect. The substance of Dr. Peters’s testimony was unusual too. She contended in effect that she meant in her letter that ordering an INR and not ordering one were both reasonable. However, that is not a common-sense reading of her statement. She wrote, “I do wish” – not simply “I wish” – and “in retrospect….” (Ex. 8) Two words and one phrase – “do,” “wish,” and “in retrospect” – all emphasize that this was a statement of regret. Dr. Peters may have adopted the position – or clarified – that both ordering an INR and not ordering one were equally reasonable – but that does not mean that she did not express regret for not ordering an INR. She did express regret in her letter of December 17, 2018. (Ex. 8)

    Only in the examination by her lawyer did Dr. Peters say, “[I]f I knew then what I know now, I would have done things differently.” (Tr. I-182) Even that statement was not as straightforward is it seems. The full quotation is: “That’s what I said: If I knew then what I know now, I would have done things differently.” That is *not* what Dr. Peters said. She studiously avoided saying that she would have done things differently. Instead, she repeatedly said that it would have been reasonable if she had done things differently.

    In any event, Dr. Peters’s testimony about this statement damaged her credibility. She did one of three possible things, each one of which damaged her credibility. She (1) denied a common-sense interpretation of the statement in her letter that she was expressing regret; or (2) denied that she could *understand* that what reads as an expression of regret can or should be read as such; or (3) admitted that she wrote what reads like an expression of regret without intending to express regret. [↑](#footnote-ref-12)
13. In its post-hearing brief, BRM cited 243 CMR 1.03(5)(a)(11). [↑](#footnote-ref-13)
14. BRM offered evidence of one other example of Dr. Peters’s alleged failure to adequately monitor the patient’s INR: after the patient exhibited bruising. BRM’s “including but not limited to” language was sufficient notice to Dr. Peters. *Mathews v. Eldridge*, 424 U.S. 319, 348 (1976) (“The essence of due process is the requirement that a person in jeopardy of serious loss (be given) notice of the case against” her) (citation and quotation marks omitted). The reason is that the third factual example of Dr. Peters’s allegedly having given substandard care concerns Dr. Peters’s care after the patient exhibited bruising. [↑](#footnote-ref-14)
15. BRM was not explicit here or in the hearing how Dr. Peters could or should have followed up. Dr. Nowak, BRM’s expert, opined that Dr. Peters should have immediately ordered an INR test. (Tr. II-86). Assuming that BRM meant that Dr. Peters “failed to properly follow-up on Patient MD’s bruising” by not immediately ordering an INR test, then this third factual example of Dr. Peters’s allegedly having given substandard care is subsumed under or at least related to the second factual example. [↑](#footnote-ref-15)
16. BRM did not explicitly allege that Dr. Peters engaged in conduct that places into question her competence to practice medicine, such as gross misconduct, gross incompetence, gross negligence, or repeated negligence; committed malpractice; engaged in misconduct; or engaged in conduct that undermines the public confidence in the integrity of the medical profession. BRM merely stated that these were the legal bases on which it could proceed against her. However, Dr. Peters’s post-hearing brief acknowledged that the statement of allegations had charged her with having engaged in conduct that places into question her competence to practice medicine, and so on. Thus, she was on notice that she had to defend against charges of malpractice, misconduct, and so on. [↑](#footnote-ref-16)
17. The parties did not brief what it means for a doctor to have engaged in conduct that places into question her competence to practice medicine, such as gross misconduct, gross incompetence, gross negligence, or repeated negligence; committed malpractice; engaged in misconduct; or engaged in conduct that undermines the public confidence in the integrity of the medical profession. I asked them to provide “definitions of negligence, malpractice, misconduct, and standard of care and/or illustrative cases that they believe I should be using.” Dr. Peters provided the model Superior Court jury instruction on medical malpractice and the BRM case involving David M. Edinburgh, M.D., (Case No. 89-3-TR, 1991), apparently for its definitions of negligence and gross negligence, *id.* at 72 n.69, as appearing in *Altman v. Aronson*, 231 Mass. 588, 591-92 (1919). BRM directed me to the definition of gross misconduct in *Hellman v. Board of Registration in Medicine*, 404 Mass. 800 (1989) and the discussion of negligence in *Board of Registration in Medicine* *v. Suzanne B. Rothchild, M.D.*, RM-06-241, RM-08-28, RM-08-157 (DALA 2013). [↑](#footnote-ref-17)