

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2023-047

In the Matter of

Richard E. Altman, M.D.

STATEMENT OF ALLEGATIONS

The Board of Registration in Medicine ("Board") has determined that good cause exists to believe the following acts occurred and constitute a violation for which a licensee may be sanctioned by the Board. The Board therefore alleges that Richard E. Altman, M.D., ("Respondent") has practiced medicine in violation of law, regulations, or good and accepted medical practice as set forth herein. The investigative docket number associated with this order to show cause is Docket No. 19-525.

Biographical Information

1. The Respondent graduated from the University of Vermont's College of Medicine in 1988. He is certified by the American Board of Medical Specialties in Urology. The Respondent has been licensed to practice medicine in Massachusetts under certificate number 79286 since 1994.

Factual Allegations

2. On February 2, 2018, a malpractice payment was made on Respondent's behalf to settle a complaint filed against the Respondent regarding his care treatment of Patient RM.
3. On July 20, 2018, a malpractice payment was made on Respondent's behalf to

settle a complaint filed against the Respondent regarding his care treatment of Patient JS.

Patient RM

4. On February 11, 2013, Patient RM presented to Respondent with a 2 cm right lower pole ("RLP") stone with mild RLP hydronephrosis.
5. Patient RM's lab results were positive for e. coli.
6. Respondent, who was aware of the positive lab results, decided to leave the urinary tract infection ("UTI") untreated because Patient RM was asymptomatic.
7. The American Urological Association's Guidelines recommend that a patient whose preoperative evaluative urine culture is positive for a UTI be prescribed appropriate antibiotic therapy.
8. On March 18, 2013, Respondent performed a right percutaneous nephrolithotripsy on Patient RM.
9. During the procedure, Respondent could not find the stone. He was unsure if it was stuck in another infundibulum or another collecting system area. But, due to bleeding and oozing, after 15 minutes of looking, Respondent elected to stop the procedure.
10. Respondent left a catheter in place, so he could possibly have a second look in the future.
11. Patient RM was sent to the PACU in stable condition.
12. In the PACU, Patient RM was noted to have significant postoperative distress. An urgent CT abdomen and pelvis scan was performed revealing fluid collecting around the kidney with dislodged nephrostomy catheter that was outside the renal collecting system in the perinephric space.
13. Patient RM was reintubated for respiratory distress and transferred to the

Intensive Care Unit ("ICU") where she continued to show signs of sepsis requiring vasopressors.

14. Patient RM continued to decline clinically and ultimately died on March 20, 2013.

15. Respondent's treatment of Patient RM fell below the standard of care in two ways.

16. First, Respondent failed to follow the American Urological Association's Guidelines' recommendation that a patient, whose preoperative evaluative urine culture is positive for a urinary tract infection, be prescribed appropriate antibiotic therapy.

17. Second, when the percutaneous nephrostomy catheter was noted to be outside of the collecting system and subsequently removed, Respondent did not place a ureteral stent.

Patient JS

18. Patient JS presented to Respondent on February 14, 2012, for a 6 mm left upper ureteral stone with hydronephrosis. After discussing surgical options, they decided to take a conservative non-surgical approach.

19. However, the next day, one of Respondent's colleagues placed a ureteral stent after Patient JS presented to the ER with an increase in his symptoms.

20. Patient JS elected to schedule a ureteroscopic stone procedure.

21. On February 27, 2012, Respondent performed a cystoscopy, left ureteroscopy, laser lithotripsy, and placed a stent.

22. During the procedure, the stone was very adherent to the wall of the ureter, but Respondent felt that when he was finished, he had lasered the great majority of the stone.

23. Respondent felt there was a lot of edema in the area and elected to leave a stent in for about three weeks, which Respondent removed without difficulty on March 16, 2012. A follow-up appointment was scheduled for early June. Respondent also planned to see Patient JS

one year later.

24. Patient JS canceled his June follow-up appointment. Apparently, the cancellation was never relayed to Respondent.

25. He returned for his one-year follow-up appointment on April 3, 2013. In response to his complaints, Respondent ordered a renal ultrasound which showed left hydronephrosis.

26. A CT scan was performed on April 7, 2013, which confirmed hydronephrosis, but also raised the question of a retained object.

27. Respondent met with Patient JS on April 10, 2013, to discuss the CT findings. They discussed the need for a percutaneous procedure.

28. Later, when Respondent's office called Patient JS to confirm the surgery appointment, Patient JS stated he would go elsewhere for further treatment.

29. On April 26, 2013, Patient JS underwent a procedure at another medical facility where an approximately 6 cm segment of wire was removed from the left renal collecting system in his left kidney.

30. The retained segment of wire was left by Respondent during his February 27, 2012 procedure.

31. The facility noted that Patient JS' left kidney appeared to be nonfunctioning.

32. Respondent failed to meet the standard of care during the surgical procedure he performed on February 27, 2012 when he failed to identify and remove a foreign object that was placed in the patient's renal collecting system during surgery.

#### Legal Basis for Proposed Relief

- A. Pursuant to G.L. c. 112, § 5, eighth par. (c) and 243 C.M.R. 1.03(5)(a)(3), the Board may discipline Respondent upon satisfactory proof to a majority of the

Board that he engaged in conduct which places into question his 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.

- B. Pursuant to 243 C.M.R. 1.03(5)(a)(17), the Board may discipline Respondent upon proof satisfactory to a majority of the Board that he committed malpractice within the meaning of G.L. c. 112, § 61.

The Board has jurisdiction over this matter pursuant to G.L. c. 112, §§ 5, 61 and 62. This adjudicatory proceeding will be conducted in accordance with the provisions of G.L. c. 30A and 801 C.M.R. 1.01.

#### Nature of Relief Sought

The Board is authorized and empowered to order appropriate disciplinary action, which may include revocation or suspension of Respondent's license to practice medicine. The Board may also order, in addition to or instead of revocation or suspension, one or more of the following: admonishment, censure, reprimand, fine, the performance of uncompensated public service, a course of education or training, or other restrictions upon Respondent's practice of medicine.

Order

Wherefore, it is hereby **ORDERED** that the Respondent show cause why the Board should not discipline Respondent for the conduct described herein.

By the Board of Registration in Medicine,



Julian N. Robinson, M.D.  
Board Chair

Date: December 21, 2023