

COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss.

Board of Registration in Medicine

Adjudicatory Case No. 2020-053

_____)
 In the Matter of)
)
 ERROL S. MORTIMER, M.D.)
 _____)

STATEMENT OF ALLEGATIONS

The Board of Registration in Medicine (the “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 Errol S. Mortimer, M.D. (the “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 Investigative Docket No. 15-036.

Findings of Fact

1. The Respondent was born on January 12, 1960. He graduated from the McGill University Faculty of Medicine in 1986. He is certified by the American Board of Medical Specialties in Orthopaedic Surgery. He has been licensed to practice medicine in Massachusetts under certificate number 81083 since 1995. He has privileges at UMass Memorial Medical Center (“UMass Memorial”).

PRIVACY CONCERNS

2. From approximately 1998 until 2008, the Respondent improperly accessed Protected Health Information of people that were not his patients on ten (10) separate occasions.

3. At the request of UMass Memorial, the Respondent underwent further education/training with respect to Protected Health Information and there have been no additional incidents involving him improperly accessing such information since 2008.

PATIENT A:

4. In October 2012, Patient A was twenty (20) years old and a complicated patient with a history of spinal/back surgeries, including an anterior release, vertebrectomy, and posterior fusion in 2004, removal of implants due to pain in 2005, and repeat anterior release, T4-L3 posterior spinal fusion, anterior thoracoscopic resection of T8 vertebral body, and osteotomies at L2-L3 and T11-T12 in 2007.

5. Patient A visited with the Respondent in June 2012 with concern that her deformity had progressed and complained of achiness in her lower back.

6. The Respondent scheduled Patient A for an anterior thoracoscopic release at T10-L1 on October 26, 2012.

7. During the surgery described in the preceding paragraph, the surgical team, led by the Respondent, encountered brisk bleeding from a vertebral body.

8. The Respondent elected to treat the bleed described in the preceding paragraph using Surgicel and electrocautery, which promptly stopped the bleeding.

9. The Respondent completed Patient A's surgery and noted that, at the end of the case, there was no residual bleeding.

10. Patient A's neurologic status was not assessed at the conclusion of the above-described surgery.

11. The applicable standard of care for spinal surgery requires a surgeon to assess the patient's neurologic status at the conclusion of a case and prior to leaving the operating room.

12. The Respondent noted on October 26, 2012 that Patient A awoke from the above-described surgery and was “essentially paralyzed below the waist.”

13. The Respondent ordered an emergent MRI in response to Patient A’s condition on October 26, 2012.

14. The MRI described in the preceding paragraph could not be properly interpreted because of instrumentation placed around Patient A’s spine and the Respondent then elected to bring Patient A back into the operating room for further surgery on October 27, 2012.

15. During the subsequent procedure of October 27, 2012, the Respondent noted that the Surgicel which he had placed in Patient A during the October 26, 2012 surgery had become firmly packed with a firm, rubbery consistency and that Patient A’s spinal cord was compressed between the Surgicel and some adjacent hematoma.

16. Patient A did not recover motor function in her lower extremities and was ultimately diagnosed with T10 paraplegia at an outpatient physiatry consult on December 19, 2012.

17. Prescribing information for Surgicel at the time of the above-described incident proscribed against leaving Surgicel in the body due to the risk of an epidural compressive lesion as the material continues to swell.

18. Although the Respondent may have conscientiously elected to leave Surgicel in Patient A’s body at the conclusion of the October 26, 2012 procedure, he should have known of the risk described in the preceding paragraph and brought her back into the operating room immediately upon noting her impaired motor and sensory function rather than ordering imaging for her as the resulting delay negatively impacted her prospects of recovery.

19. In or around January 2013, the Respondent was invited to and attended a party together with the UMass Memorial Patient Care Representative to celebrate Patient A's twenty-first birthday and contributed financially to a birthday present for Patient A.

PATIENT B:

20. In August 2013, Patient B was four (4) years, eleven (11) months old and had a complex medical history including but not limited to failure to thrive, pituitary dwarfism, and pulmonary stenosis in addition to arthrogryposis with bilateral, neuromuscular club feet.

21. The Respondent performed reconstructive surgery on Patient B's left club foot on August 9, 2013.

22. In performing the surgery described in the preceding paragraph, the Respondent achieved the desired correction to Patient B's foot, pinning the hindfoot to the tibia and also securing the forefoot correction with a pin.

23. Patient B was discharged from UMass Memorial in the evening of August 10, 2013.

24. On August 11, 2013, Patient B's mother measured his temperature to be 102.5° F and brought him to the emergency department at UMass Memorial.

25. Patient B was subsequently readmitted to UMass Memorial and the admission note documented that his mother observed that his left small toe was then "black" than it had been the preceding day.

26. The Respondent next saw Patient B on August 12, 2013 at approximately 8:15 pm and described concern over decreased circulation to Patient B's foot in his note for that visit.

27. At approximately 11:00 pm on August 12, 2013, Patient B was transferred to the surgical intensive care unit due to vascular compromise of the left foot.

28. The Respondent saw Patient B again on August 14, 2013 and recorded in the note for that visit his belief that the patient's circulation issues were then resolving with elevation and time.

29. The Respondent saw Patient B again on August 15, 2013 and noted that Patient B's skin was becoming increasingly purple but cited superficial bullae as a potential reason for that change. He recommended that Patient B then be weaned off of Nicardipine, an antihypertensive drug, and to continue elevation and warmth for the affected foot.

30. On August 18, 2013, an orthopaedic surgery progress note from 7:00 am on August 18, 2013 stated that Patient B then had no sensation over his toes and was experiencing necrosis of the small toe and the tips of the second, third, and fourth toes. The Respondent was immediately called to evaluate the patient.

31. The Respondent saw Patient B on August 18, 2013 and noted that the patient's small toe appeared necrotic and that the second, third, and fourth toes appeared necrotic at their tips. He further recorded a plan to continue observing Patient B in the intensive care unit until the following day and to then begin planning discharge to a hospital floor or to home with nursing assistance.

32. Patient B was discharged once again from UMass Memorial on August 21, 2013.

33. On September 3, 2013, Patient B underwent surgical amputation of toes 2-5 performed by the Respondent and another provider and the operative report noted "clearly necrotic gangrenous material amputated."

34. On September 11, 2013, Patient B underwent debridement of his necrotic tissues, resection of necrotic navicular, and wound vac dressing performed by the Respondent and other providers.

35. On September 13, 2013, Patient B underwent surgical amputation of his midfoot/forefoot performed by another provider with the Respondent assisting.

36. The appropriate corrective measure following observation of decreased perfusion and/or vascular function and the necrotic appearance of the patient's small toe would have been immediate removal of the pins inserted during surgery to relieve tension from the posterior tibialis artery.

37. In fact, the pins holding Patient B's foot correction were not removed until August 29, 2013.

Legal Basis for Proposed Relief

A. Pursuant to Mass. Gen. Laws c. 112 § 5, eighth par. (c) and 243 Mass. Code Regs. 1.03(5)(a)(3), the Board may discipline a physician upon proof satisfactory to a majority of the Board that said physician has engaged in conduct that places into question the physician's competence to practice medicine, including but not limited to negligence on repeated occasions.

B. Pursuant to 243 Mass. Code Regs. 1.03(5)(a)(11), the Board may discipline a physician upon proof satisfactory to a majority of the Board that said physician has violated any rule or regulation of the Board, to wit:

a. 45 C.F.R. § 160.

C. Pursuant to 243 Mass. Code Regs. 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.

D. Pursuant to 243 Mass. Code Regs. 1.03(5)(a)(18), the Board may discipline a physician upon proof satisfactory to a majority of the Board that said physician has committed misconduct in the practice of medicine.

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 CMR 1.01.

Nature of Relief Sought

The Board is authorized and empowered to order appropriate disciplinary action, which may include revocation or suspension of the 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 the Respondent's practice of medicine.

Order

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

By the Board of Registration in Medicine,



George M. Abraham, M.D.
Board Chair

Date: December 4, 2020