

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2018-063

In the Matter of

HOOSHANG D. POOR, 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 Hooshang D. Poor, 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. 15-030.

Biographical Information

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

Factual Allegations

Patient A

2. Patient A is 61 year-old man who was treated at a hospital for a gastrointestinal bleed after surgical anastomosis and thereafter admitted to a skilled nursing facility on December

3, 2012, where he was under the care of the Respondent. Patient A had a number of conditions including congestive heart failure, chronic atrial fibrillation, end-stage renal disease from nephrosclerosis, hypertension, mild diabetes, and clostridium difficile colitis.

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

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

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

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

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

Patient B

7. The Respondent provided care to Patient B, who was a 62 year old woman admitted to a skilled nursing facility following a diagnosis of chronic atrial fibrillation, congestive heart failure, ischemic heart disease, chronic obstructive lung disease, peripheral

arterial disease, drug dependency, anxiety, depression, and degenerative disc disease, which ... resulted in radiculopathy and chronic pain.

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

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

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

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

Patient C

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

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

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

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

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

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

Patient D

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

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

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

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

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

22. Patient D had history of hypertension, congestive heart failure, and renal failure and was hospitalized for dehydration and pre renal azotemia. While staff records contain notes

documenting the patient's weights, vital signs and labs, the Respondent had few personal notes which documented Patient D's vital signs, including weight gain, which would have tracked whether these health problems were being controlled.

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

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

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

Legal Basis for Proposed Relief

A. Pursuant to G.L. 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 he/she 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 G.L. c. 112, §5, eighth par. (h) and 243 CMR 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 of a rule or regulation of the Board. Specifically:

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

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,

Candace Lapidus Sloane, MD

Candace Lapidus Sloane, M.D.
Board Chair

Date: *December 20, 2018*