

STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS

DEPARTMENT OF HEALTH :
BOARD OF MEDICAL LICENSURE :
AND DISCIPLINE :

IN THE MATTER OF :

AARON R. SHERMAN, M.D. :
LICENSE NUMBER: MD 7252 :

NO. COO-024
COO-158
CO2-170

ADMINISTRATIVE DECISION

This matter came on for hearing before a duly appointed hearing panel of the Board of Medical Licensure and Discipline (hereinafter "Board") on diverse dates between July 1, 2004 and January 11, 2006.¹

**TRAVEL, TESTIMONY AND
FINDINGS OF FACT**

On or about March 25, 2004, the State filed a Specification of Charges against the Respondent containing 16 counts of conduct on the part of the Respondent that the State contends constitutes unprofessional conduct in violation of § 5-37-5.1 of the R.I. General Laws.

The Specification of Charges, though numerous, center around three (3) basic issues. Essentially, the State alleges that the Respondent was unprofessional in his treatment of a young female patient on September 21, 1994; that the Respondent failed to

¹ During the course of the hearing, there were a number of continuances granted largely at the request of the Respondent's counsel, thereby prolonging the hearing. As a result of that fact, the composition of the hearing committee also changed. Two members were replaced during the hearing. The new committee members have read the transcript of earlier hearing dates and have examined all of the evidence in reaching this decision.

keep adequate patient records and/or follow-up with patients; and that the Respondent maintained a hostile work environment in his office.

The State produced several witnesses as part of its prosecution of the case. The following pertinent facts can be deduced from the evidence presented at hearing.

Patient A testified that she began treating with the Respondent in March of 1994. In the summer of 1994, she developed a urinary tract infection for which she sought the Respondent's help. She experienced a recurrence of the infection in September and again called upon the Respondent. The witness testified that on September 21, 1994, she arrived at the Respondent's office at approximately 8:30am. After waiting a short time, the patient was escorted to the examination room by a female employee in the office. The woman then left the room after instructing the patient to strip from the waist down. She did so, and she sat on the examination table with a covering over her. When the doctor came into the room, he was alone. The patient described her symptoms and suggested that she might have another urinary tract infection. The Respondent swabbed the vaginal area at which time the patient felt a "pinch". She suddenly felt tired and faint and expressed that to the Respondent. According to the patient, the Respondent told her that he had ruptured a cyst, that cysts secrete morphine and that her faintness would pass. The Respondent told the patient that he was going to continue the vaginal probe. The patient stated that she then "passed out" or fell asleep. When the patient awoke, the Respondent was still in the room. She felt groggy, and he told her to stay in the room until she felt better. A short time later, the Respondent returned to the room and told her that he was calling the Emergency Room at Kent County Hospital for advice about her symptoms. The Respondent came back and reported to the patient that the staff at the

hospital had agreed that the “fainting” spell was related to the cyst. The patient was still not feeling right, so she called a friend who came to pick her up at the Respondent’s office. Once at her friend’s house, the witness stated that she did not get very much better. She was awake, but she felt as though she were in a “daze”. Her friend called 911, and the rescue took her to the Kent Emergency Room. The witness testified that, once there, blood tests were ordered. The results showed a high amount of benzodiazepine in her blood. She advised hospital personnel that she had not taken any drugs nor had she consumed any alcohol.

On cross-examination, the witness admitted that in one of her earlier statements, she had maintained that the Respondent, rather than one of his staff, had directed her to the examination room. The witness also admits that she did not see a “syringe” at any time, but she also stated that there was a drape over her that partially obscured the Respondent’s hands as he removed them from her vagina.

The witness reiterated that after the pinch, she felt immediately groggy. The Respondent sat her up and told her that he had hit a cyst that had released morphine into her system causing the drowsiness. She stated that she then passed out. When she awoke, the Respondent was in the room. He told her that she had been “out” for approximately ½ hour during which time he had performed a probe ultrasound. The patient informed the Respondent that she was experiencing pain in her neck, similar to that which she had experienced when she had an allergic reaction to compazine. At that point in time, the Respondent advised her that he had called the Kent Emergency Room and allegedly spoke to someone there concerning her symptoms. He then told her to sit in his waiting room until she felt better. Instead, she called her friend to come pick her

up at the Respondent's office. The patient also testified that when she arrived in the Kent Emergency Room, the Respondent was apparently in the hospital and was called down to the Emergency Room to speak with the emergency room physician, Dr. Riedel. The Respondent did not speak to her in the hospital, but she observed him speaking with Dr. Riedel within a few feet of her.

The patient was admitted to the hospital overnight. She was discharged the next day. The discharge summary contains a primary probable diagnosis of vaso vagal syncope (Exhibit State's 13). The patient testified that she was also told by the emergency room doctor that she may have had a reaction to the benzodiazepine.

The State called John Riedel, M.D. as a witness in the case. Dr. Riedel testified that the patient arrived at the Kent Hospital Emergency Room on September 21, 2004 complaining of having had a seizure. She was extremely anxious as she did not know what had happened to her or why. Dr. Riedel ordered blood tests in an effort to determine what was wrong with the patient. The patient's blood tested positive for the presence of benzodiazepine. The patient denied taking any drugs. Dr. Riedel testified that he spoke to the Respondent who advised that he had administered the benzodiazepine to the patient. There was no explanation given as to why the drug was administered to the patient.

The witness stated that the patient's chief complaint was about the seizure. However, he stated that she was also very upset and "a little hysterical" about her situation. She did not understand why she was in her present situation. A psychiatric consultation was ordered. The result of the consultation was that the patient had no

underlying psychiatric problem, nor was she a drug user. She was just concerned about the seizure.

On cross-examination, the doctor testified that following examination of the patient and tests, he charted three possible diagnoses: (1) a ruptured ovarian cyst; (2) a vaso vagal reaction; and (3) situational adjustment reaction. Dr. Riedel diagnosed the first two from the history he obtained from the Respondent and the patient. The third related to the patient's concern and confusion as to why she experienced the seizure.

The doctor testified that he firmly believes that the Respondent administered benzodiazepine to the patient. He did not chart that fact because that is not what he determined to be important. Rather, he was focused on the seizure. His role as an emergency room physician was to rule out rapidly resolving seizures, those that do not require admission. The benzodiazepine didn't relate to his examination, as benzodiazepine is ordinarily a treatment for seizures, it doesn't cause them.

Dr. Riedel testified that from his discussion with the Respondent, Dr. Riedel assumed that the Respondent had physically administered benzodiazepine to the patient, not given her a prescription for it. But, he stated that the Respondent did not specifically say how he gave it to the patient. He did not say how much of the drug he gave her, but the Respondent did tell Dr. Riedel that the patient was very upset (about the ruptured cyst) and that was why he administered the valium (benzodiazepine).

George Sehl, D.O. also testified. Dr. Sehl examined the patient and admitted her to the hospital. He recalled that he understood that the patient had been administered valium, but Dr. Sehl did recollect the source of his knowledge. Dr. Sehl's final diagnosis of "vaso vagal syncope" was prefaced on the history that the Respondent ruptured a cyst

and blood loss ensued. A vaso vagal syncope is pain with a loss of consciousness due to a slowing of the heart rate. This could occur if the Respondent had punctured a cyst in the patient. It does not explain the presence of valium in the patient's blood.

The doctor did state that the syncope episode could be caused by the introduction of drugs to the patient's body. He testified that he has had occasion to use injectable valium on patients and that, when given intravenously, the patient usually loses consciousness.

With respect to this incident, the State also elicited direct testimony from the Respondent. The Respondent is a board certified OBGYN physician. While he engages in a general OBGYN practice, the Respondent stated that he has a significant interest in fertility, and that patients experiencing fertility problems are within his patient population.

The Respondent testified that according to his office chart, this patient came to his office on September 21, 1994 for follow-up of cysts. The Respondent testified that he first conducted a manual internal exam of the patient. He stated that it was at this time that the patient experienced a vaso vagal reaction during which she became "lightheaded" and disoriented. He stated that the patient told him she was dizzy. He testified that her eyes were rolling in her head. He said he sat her up to make sure that her airway was clear. Apparently, the patient did pass out because the Respondent testified that he left the room to attend to other patients. He stated that he left a medical assistant with the patient. The Respondent stated that when he returned to the room the patient seemed to have recovered, so he continued his examination. He did an ultrasound on the patient, after which she did not appear well. The Respondent testified on direct examination by

the State, that he then called Dr. Mello at Kent County Hospital to discuss the patient's symptoms. He suggested to the patient that she go for follow-up at the hospital, but that she declined. In his subsequent testimony, during the defense portion of this case, the Respondent testified alternatively that he had telephoned Dr. Mello immediately after the patient had fainted, before she awakened, and before he conducted the ultrasound. The Respondent's testimony is also contradictory to a letter that he had submitted to the Board in response to the patient's complaint (See State's Exhibit 12). In his testimony before the Board, the Respondent stated that the patient's vaso vagal reaction occurred during his manual internal examination, whereas in his letter to the Board, the Respondent stated that the patient's vaso vagal reaction occurred during the ultrasound portion of his examination. In his live testimony, the Respondent stated that his letter was in error. The Respondent also denied that he told Dr. Riedel or anyone that he administered benzodiazepine or valium to the patient. The Respondent maintained that he does not keep valium in the office. In support of that testimony, the Respondent produced testimony from Pamela Cross, who was the Respondent's office manager from 1992 until 1997. She stated that during that time period, she did not order or pay for any valium. She further stated that she had never seen any valium in the office, although there were needles and syringes in the office.

The Respondent also called an anesthesiologist, Arthur A. Bert, M.D., as a witness. Dr. Bert testified that valium is a multi-purpose drug with which he has had familiarity in excess of 25 years. He stated to a reasonable degree of medical certainty that valium does not cause seizures, that it is the first line drug to prevent seizures. He

further stated that the amount of valium necessary to bring on an unconscious state, if injected vaginally, would require more than 10mg, more toward 20-30mg.

Upon review of the evidence, it is not clear at all that the patient actually suffered a seizure. The testimony is that the patient's eyes rolled back in her head, at which time her friends called the ambulance. The patient may have suffered a recurrence of the symptoms that she exhibited at the Respondent's office and mischaracterized it as a seizure. No evidence of seizure activity was found by the staff at the hospital.

The Board notes further that the Respondent's testimony was inconsistent in many respects. At some point, he explains the patient's symptoms as being a vaso vagal episode, then alternately he says that he ruptured a cyst. Neither is noted in his patient chart. Nor is there any evidence of an ultrasound having been performed despite Respondent's testimony to that effect. The Respondent first testified that the patient never lost consciousness. He then changed that testimony and maintains that when the patient lost consciousness, he left her in the examination room with a medical assistant. There was no evidence presented from the medical assistant that is what occurred. The more credible evidence is that which was deduced from the patient, i.e. that when she lost consciousness, she was in the room alone with the Respondent. She was unconscious for about one-half hour. When she awakened, she was still alone in the room with the Respondent. The Board cannot speculate as to what may have occurred during the half-hour that the patient was unconscious. However, the Board can conclude from the testimony that it is more likely than not that the Respondent did inject the patient with valium, which is a sedative and which brought about the patient's state of unconsciousness. The Board finds as credible the patient's declaration that she took no

drugs, as well as Dr. Riedel's testimony that valium or benzodiazepine was found in the patient's blood, and that the Respondent told him that the Respondent had administered it to the patient. The Board concludes that the medical care that the Respondent provided to the patient did not comport with the accepted standards of medical practice and that the Respondent is guilty of Counts One through Five of the Specification of Charges.

Pursuant to Counts Six, Seven, Nine and Eleven, the Respondent is charged with mismanaging patients and lack of follow-up on patient PAP smears. The Respondent testified that PAP smears are a large part of his practice requiring follow-up on each one. The Respondent testified that PAP smears were always sent to the same laboratory. When the results were returned, they were entered into a book. The Respondent testified that his nurse practitioner was allotted two hours per day to contact patients with abnormal PAP smears. He stated further that he had a medical assistant who assisted the nurse practitioner by making sure that the results of normal and abnormal PAP smears were logged into the book. The abnormal ones were placed in a separate pile to be looked at by the nurse practitioner. The Respondent testified that it was his policy to have every lab report signed off on by the nurse practitioner. He admitted, however, that once the medical assistant and the nurse practitioner began working together they may have developed a different system whereby the nurse practitioner may have only looked at the abnormal PAP smears. The office procedure was to log in the patient's PAP smear before it was sent out to the laboratory and then to check the log book once a month to make sure the laboratory analysis came back. He stated that the turnaround time for the laboratory is about 22 days. If the laboratory results were not returned in a timely fashion, it was the medical assistant's responsibility to follow-up with the laboratory

directly. With respect to abnormal PAP smears, it was the nurse practitioner's job to call and explain the situation to the patient. In some cases, the patient would request to speak with the doctor to further explain the laboratory analysis. This usually happened with respect to patients whose results that were "high grade" abnormal.

To support the charges that the Respondent was negligent in reviewing PAP smear results and following up with the patient, the State presented documentary evidence of failed follow-up for several patients (States 7,8,9,10). On adverse examination, the Respondent acknowledged that State's 7 was a Notice from Women & Infants Hospital that PAP smears denoting abnormal cytology had no follow-up as far as the hospital was aware. The PAP smears were taken in November and December 1999. The letter identifying failed follow-up was dated September 11, 2000. State's 8, 9 and 10 reflect three instances wherein the Respondent did not contact patients whose PAP smear results were "low grade" abnormal. The Respondent testified that, as to one of the patients, he was unable to reach her. As to the other two patients, he marked the reports to repeat the PAP smears, in one case at 6 months, and in the other case, at 3-4 months.

The State's next witness following the Respondent was Donna Polacastro, a women's health nurse practitioner (hereinafter "NP") who was employed in the Respondent's office from September 1995 until November 2000. The NP testified that when she started in the office, it was just she and the Respondent who saw patients. As the office got busier, another physician, a nurse midwife and an RN were hired. The NP stated that PAP smears were sent by courier to Women & Infants Hospital every day, and the results were returned the same way. Each clinician had a log book to log out the PAP smears and to log them back in upon receipt of results from the hospital. She said it was

a precautionary measure taken to assure that the results were returned in a timely manner. She further stated that when she and the Respondent were working the office alone, that she was the person responsible for looking at the results of each PAP smear. The normal results were filed, and the abnormal ones were handled by her with some assistance from the Respondent. The NP testified that as time went on, the new clinicians were added and each of them had his or her own medical assistant. At that time, the office practice changed such that each clinician, in consort with his or her medical assistant, was responsible for his or her own lab work. She testified that Exhibit 9 contained a note indicating that the chart was handed off to the Respondent on February 10, 2000 due to an abnormal PAP smear result. She testified that the patient called the office at the end of October 2000 complaining about vaginal bleeding. The NP stated that the Respondent had failed to notify the patient about her abnormal results from the previous February.

On cross-examination, the NP did say that in response to complaints about failed follow-up, the Respondent developed policies and procedures for the handling of PAP smears and other lab tests. She further stated that she did not know how the State came into possession of the three patient charts, nor did she know how many files the State had to examine before finding the three with failed follow-up.

The State also called as a witness, Paula Santiano, a medical assistant who worked in the Respondent's office for approximately 11 months in 2000. The witness testified that she had no involvement with the PAP smears themselves. However, she stated that she would take calls from patients who were seeking to know the results of their PAP smears. When she would pull the patients' charts, she sometimes found abnormal results with no follow-up indicated. She reported that fact to the office

manager. Toward the end of her employment with Respondent, the witness testified that she was being asked to contact patients to report abnormal PAP smears. She stated that she was uncomfortable undertaking that responsibility as she did not possess sufficient medical knowledge to respond to the patients' questions.

The witness also testified relative to the condition of the Respondent's office. She agreed that the Respondent's private office was in complete disarray with files and/or patients' lab reports being piled on the desk, chair and strewn around the floor.

The State next called as a witness, Andrea DeCiantis, a nurse midwife (CNMW) who commenced working for the Respondent in 1998. Ms. DeCiantis testified that she worked with the Respondent from January of 1998 to February 2000. She stated that, initially, and continuing for most of the time of her affiliation with the Respondent, the Respondent provided "good quality care", and that she was proud to work with him. However, after approximately 18 months, conditions changed. She became concerned about patient follow-up with abnormal PAP smears and mammograms. The witness testified that patients were not being promptly notified. She further stated that when the office was slow, she and her colleagues cleaned up the Respondent's office and prioritized abnormal PAP smears so the Respondent could address them. She stated that some laboratory results were a year old with no follow-up noted in the charts. In an earlier deposition, she guessed that there were perhaps 50 charts that appeared to need the Respondent's attention. When she provided this information to the Respondent, the witness said he became aggravated that they had reorganized the files in his office. The witness did admit that the Respondent at all times seemed able to locate patients' charts despite the unkempt condition of his office. She further testified that she did not make a

list of PAP smear results that were not followed-up. She stated that the office saw +/-80 patients a day and did "at least" 50-75 PAP smears a week. She also stated that the lab results were sent back in batches of +/-50, so at any one time, there were a number of lab results to look over and patients to be contacted.

In late 1999, the CNMW decided to leave the Respondent's practice despite the fact that she was working under an employment contract. She stated that she did so due to a list of concerns about the practice. The witness indicated 10 reasons for her departure, 3 or 4 of which were patient-related, with the remainder being financially based. The witness testified that bills were not being paid by the Respondent, and she feared that repercussions to the practice would follow as a result. When she left the practice, the Respondent initiated a civil suit against her. The Respondent had loaned her money to attend midwifery school, and she had promised to work in his office. When she left his employ, the Respondent sued her on the loan, for breach of contract and for solicitation of his patients to her new office. The witness settled the case by paying the Respondent a nominal amount.

Counts Six and Eleven of the Specification of Charges alleges that the Respondent was guilty of unprofessional conduct due to his mismanagement of patients and lack of follow-up on PAP smear results that were positive for abnormalities. With respect to those Counts, the State has provided evidence of 3 specific patients for whom follow-up was not provided, whereas the testimony of both the Respondent and his nurse midwife support a finding that the Respondent's office was performing +/-2500 PAP smears a year. Further, it is clear that the Respondent had a protocol for handling PAP smears, and that he allotted 2 hours per day for staff to devote to reviewing laboratory

results. The Board concludes that the Respondent is not guilty of unprofessional conduct as to Counts Six and Eleven.

Count Seven alleges that, when confronted by office staff, the Respondent altered a patient's record to reflect that she was notified of her lab results. The State presented no evidence as to the allegations contained in Count Seven. Therefore, there is no finding of unprofessional conduct as to that Count.

In Count Nine, the Respondent is accused of delegating the reporting of abnormal PAP smear results to medical assistants who were not qualified to perform that function. The evidence is that at least one medical assistant was asked to perform that function, and that she was not comfortable with it. The Board agrees that the Respondent's conduct in this regard did not comport with the best medical practices, but it is not clear that medical assistants are prevented from reporting abnormal results to patients. Therefore, the charges as to Count Nine are unfounded.

Count Eight charges the Respondent with unprofessional conduct due to keeping a messy office with patient charts being located on the desk, piled on chairs and on the floor. There was significant testimony from the staff of the practice that Respondent's office was, in fact, in disarray, and that they often times were unable to locate files that the Respondent had brought into his private office. Anecdotally, one staff member, the nurse practitioner, testified that on one occasion the fire alarm went off and fire personnel responded to the office. They inquired whether the Respondent's office had been ransacked. For his part, the Respondent denied that he kept files in his office. That testimony was not credible in light of the witness' testimony and the demonstrative

evidence that was presented (State's 5). The Respondent's lack of honesty with respect to the condition of his office and the fact that he kept files there weighs against the credibility of the Respondent's testimony with respect to the other issues for hearing in this matter. Although staff witnesses expressed difficulty in finding files, they admitted that Respondent could always immediately recover the file, despite the confusion in his office. Though the Board does not condone the manner in which the Respondent maintained his private office, there is no evidence that patients were harmed as a result, and the Board will not attach a finding of unprofessional conduct to charge that the Respondent kept an unkempt office.

Counts Ten, Fourteen and Fifteen allege that the Respondent maintained a hostile work environment by making abusive and inappropriate comments in the office and by keeping hardcore pornography in the workplace where it was likely to be seen by female staff.

Relative to the keeping of pornographic materials, the record is clear that these materials were at all times maintained in a desk drawer inside the Respondent's private office. There is no testimony that establishes that those materials were in plain view of staff looking for files in the office. As a matter of fact, the testimony of all witnesses established that the staff purposely went into the Respondent's drawer looking for these materials. One witness said she was "curious" about them. The Respondent testified that he kept the pornographic materials as an aid to his fertility patients. The practice of providing pornographic materials to fertility patients in the course of their medical treatment was supported by a fertility expert who was asked to testify, Mark Sigman, M.D. Dr. Sigman testified that he regularly maintains and uses the same types of

pornographic materials in treating his patients. He further stated that it was acceptable medical practice to do so.

Regarding inappropriate remarks being made by the Respondent to staff, and on one occasion, to a pharmaceutical representative, there is evidence to suggest that the Respondent did make some remarks that, in an OBGYN practice may have been intended as office banter, but that were clearly unacceptable to some staff members. Respondent's conduct was certainly inappropriate and wrought anger and embarrassment upon staff, but it does not rise to the level of unprofessional conduct.

As to Count Twelve, there is no testimony that establishes that the Respondent supplemented his patients' records with notes that were made in a manner designed to mislead the file reviewers into thinking that the notes had been made contemporaneously with the patients' treatment. Accordingly, Count Twelve is dismissed.

As to Count Thirteen, there is no evidence to suggest that the Respondent delayed or refused to send patient medical records to subsequent health care providers. Count Thirteen is not supported by the evidence and is dismissed.

Finally, as to Count Sixteen, it is alleged that the Respondent unreasonably delayed a patient in need of a Cesarean section from receiving prompt and necessary attention while in the hospital. The nurse midwife did provide testimony concerning an argument that took place between her and the Respondent in the corridor and lounge of the hospital at a time when they were attending to a woman who was awaiting a C section. The nurse midwife testified that the patient was loudly calling for the nurse midwife while the Respondent continued talking to her in the lounge. The Respondent

did not rebut that testimony. Although the Respondent's altercation with his staff member while in the hospital setting was inappropriate, there is insufficient evidence that it prevented the patient from receiving "prompt and needed" medical attention. Count Sixteen is therefore dismissed.

CONCLUSION

The Board hereby finds that the Respondent engaged in unprofessional conduct in his care and treatment of Patient A. Though the Board can merely speculate as to his reasons for doing so, it is apparent from the credible testimony on the record that the Respondent did inject the patient with benzodiazepine (or valium); that the patient was unconscious or asleep for approximately one-half hour during which time the Respondent either remained in the examination room alone with her or left her unattended; that his testimony relative to what treatments were rendered to the patient and the sequence of events on the date in question is inconsistent; and that the Respondent failed to document anything in the patient's record. Respondent's course of action with respect to patient A did not conform to the standards of medical practice and constitutes unprofessional conduct deserving of discipline pursuant to § 5-37-5.1 of the General Laws.

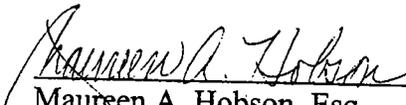
ORDER

The following is hereby **ORDERED**:

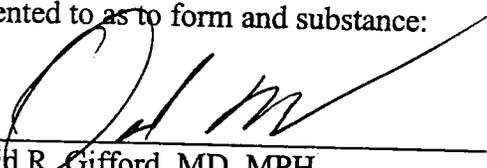
1. That Respondent is hereby issued a **REPRIMAND** against his license to practice medicine; and

2. That as a condition of continuing to be licensed as a physician in this State, the Respondent forthwith seek evaluation by the Physicians Health Committee and undertake such action as the Committee recommends to the Respondent; and
3. That the Respondent provide evidence of compliance with paragraph 2 to the Board of Medical Licensure & Discipline.

Entered this 18TH day of July, 2006.


Maureen A. Hobson, Esq.
Hearing Officer for the
Hearing Committee
Noubar Kessimian, MD
Henry Litchman, MD
Shelagh McGowan

Assented to as to form and substance:


David R. Gifford, MD, MPH
Director of Health

If you are aggrieved by this final agency order, you may appeal this final order to the Rhode Island Superior Court within thirty (30) days from the date of mailing of this notice of final decision pursuant to the provisions for judicial review established by the Rhode Island Administrative Procedures Act, specifically, R.I. Gen. Laws § 42-35-15.

CERTIFICATION

I hereby certify that I have mailed a copy of the within Administrative Decision by regular mail, postage prepaid, to David W. Carroll, Esquire, 10 Weybosset Street, Providence, RI 02903 on this 22nd day of May 2006.

Carole Allsworth