Pursuant to R.I. General Laws §5-37-5.2 1956, as amended, (2009 Reenactment) a notification was received by the Board of Medical Licensure and Discipline ("Board") regarding Edward Akelman, M.D. ("Respondent"). This matter was referred to the Board Investigating Committee for review and recommendation. The following are findings of fact and conclusions of law:

A. FINDINGS OF FACTS AND CONCLUSIONS OF LAW

1. The Respondent graduated from Dartmouth Medical School in 1978. The Respondent received his Rhode Island medical license in December 1984. His primary area of practice is General Orthopedic and Hand Orthopedic Surgery. The Respondent has hospital privileges at both Rhode Island Hospital and Women and Infants’ Hospital.

2. The Patient has been under the Respondent’s medical care since 2004 and has had multiple hand surgeries due to her distal interphalangeal ("DIP") degenerative joint disease in both of her hands.

3. The Patient scheduled an office visit with the Respondent on September 23, 2009 to discuss her severe pain in her right middle finger and right small finger. The Respondent diagnosed the patient with right middle finger trigger, right middle finger DIP degenerative joint disease, and right small finger DIP degenerative
joint disease. The Respondent discussed the surgical options with the Patient and subsequently scheduled two surgical procedures (release of the right middle trigger finger and right small finger DIP fusion) on October 22, 2009 at Rhode Island Hospital.

4. The Patient was admitted to Rhode Island Hospital on October 22, 2009 for her two elective surgical procedures on her right middle and small finger. The staff nurses conducted the pre-operative assessment by confirming the Patient identity, surgical procedures and surgical sites on the patient’s right forearm per Hospital policy. However, the Respondent proceeded to perform a wrong-site surgery by completing a right middle finger trigger release and DIP fusion instead of a right middle finger trigger release and right small finger DIP fusion. The Patient remained sedated and unconscious in the Operating Room for post-operative recovery.

5. After the Respondent was notified that a wrong-site surgery was conducted, the Respondent self-reported the incident to the appropriate Rhode Island Hospital administration and acquired consent from the Patient’s contact to perform corrective surgery on the small finger immediately.

6. The Respondent returned to the Operating Room to conduct the right small finger fusion. The patient tolerated the procedure well and the Patient returned to the Recovery Room in stable condition. The Respondent informed the Patient after her recovery that three surgeries were performed on her right hand instead of the two consented surgeries.
7. The hospital identified that the Respondent failed to follow hospital policy and procedures regarding the standard of care for surgical services.

8. The Board of Medical Licensure and Discipline determined that the Respondent failed to follow hospital policy procedures regarding the standard of care for surgical services. The Respondent is in violation of Rhode Island General Laws § 5-37.5.1 (19).

B. THE PARTIES AGREE AS FOLLOWS:

Respondent admits to the jurisdiction of the Board.

(1) Respondent hereby acknowledges and waives:

a. The right to appear personally or by counsel or both before the Board;

b. The right to produce witnesses and evidence in his behalf at a hearing;

c. The right to cross examine witnesses;

d. The right to have subpoenas issued by the Board;

e. The right to further procedural steps except for specifically contained herein;

f. Any and all rights of appeal of the terms of this Consent Order;

g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review;

h. Any objection to the fact that it will be necessary for the Board to become acquainted with all evidence pertaining to this matter in order to review adequately this Consent Order

(2) Acceptance of this Consent Order constitutes an admission by the Respondent that the findings of fact were made by the Board.
(3) This Consent Order shall become part of the public record of this proceeding once it is accepted by all parties.

(4) Failure to comply with this Consent Order, when signed and accepted, shall subject the Respondent to further disciplinary action.

(5) Respondent hereby consents to a reprimand.

(6) Respondent agrees to pay an administrative fee of FIVE HUNDRED ($500.00) DOLLARS within 60 days of ratification of this Order.

Signed this 26th day of July, 2010.

Edward Akelman, M.D.

Ratified by the Board of Medical Licensure and Discipline at a meeting held on 17th, 2010.

David R. Gifford, MD, MPH
Director of Health