COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX, SS.

BOARD OF REGISTRATION
IN MEDICINE

ADJUDICATORY NO. 2008-053

In the Matter of

Elizabeth Darr, M.D.

STATEMENT OF ALLEGATIONS

The Board of Registration in Medicine ("Board") has reason to believe that Elizabeth Darr, M.D. ("Respondent") has provided substandard care to six patients in Board of Registration in Medicine docket number 06-618.

BACKGROUND INFORMATION

1. The Respondent was born on July 1, 1946. She graduated from Tulane University School of Medicine in 1990. The Respondent is board-certified in obstetrics and gynecology. The Respondent has been licensed to practice medicine in Massachusetts under certificate number 214133 since August 21, 2002.

FACTUAL ALLEGATIONS

Disciplinary Action

2. On November 22, 2006, Fallon Clinic suspended the Respondent's gynecological surgical privileges. The suspension was imposed due to the Respondent's high surgical complication rate.

3. On March 2, 2007, Fallon Clinic terminated the Respondent's employment for cause.

12/17/08 15 2

Patient A

4. Patient A, a thirty-nine-year-old female, had hysterectomy surgery performed by the Respondent on October 23, 2006.

5. During the surgery, the Respondent ligated the right ureter and did not detect it until several days after the surgery.

6. Because of the right ureter ligation, the patient required a prolonged hospital stay and the placement of a nephrostomy tube for urine drainage.

7. The Respondent failed to order a cystoscopy or ask for a urology consult during the procedure to confirm the patency of the ureters.

8. The Respondent failed to meet the standard of care with regard to Patient A.

Patient B

9. Patient B, a forty-seven-year-old female, had hysterectomy surgery performed by the Respondent on March 6, 2006.

10. The pre-operative work-up ordered by the Respondent revealed that Patient B had a platelet count of 87,000.

11. The Respondent proceeded with Patient B's surgery without following up on the platelet count and without consulting with hematology prior to the surgery.

12. Post-operatively, the Respondent ordered Toradol and Motrin for pain relief, both of which can exacerbate bleeding problems.

13. The Respondent did not request a hematology consult post-operatively.

14. On March 14, 2006, Patient B was re-admitted with a pelvic hematoma, a low platelet count, anemia, and severe pain.

15. The Respondent failed to meet the standard of care with regard to Patient B.

Patient C

16. Patient C, a thirty-six-year-old female, had a vaginal hysterectomy surgery performed by the Respondent on August 10, 2004.

17. Patient C was discharged on August 11, 2004.

18. Patient C presented to the Respondent's office on August 19, 2004 complaining of fever and severe pain.

19. The Respondent sent Patient C for an ultrasound at Milford Hospital on that same day.

20. Patient C was subsequently admitted to St. Vincent's Hospital with a diagnosis of peritonitis.

21. Patient C required further surgery and an extended hospital admission.

22. The Respondent's decision to send Patient C for an ultrasound instead of a direct admission was inappropriate.

23. The Respondent failed to meet the standard of care with regard to Patient C.

Patient D

24. Patient D, a fifty-nine-year-old female, had a total abdominal hysterectomy, with removal of both ovaries, performed by the Respondent on August 18, 2006.

25. Patient D had a history of simple cystic endometrial hyperplasia, morbid obesity, hypertension, smoking, and three prior cesarean sections.

26. Patient D was at a very high risk for surgical complications.

27. During the procedure, the Respondent punctured Patient D's bladder and another surgeon was called to repair the bladder.

28. The patient recovered and was discharged from the hospital on August 20, 2006.

29. The Respondent's decision to perform this surgery on Patient D was not appropriate.

12/17/08 15 4

Patient E

30. Patient E, a forty-one-year old female, was seen by the Respondent on October 15, 2003 for follow-up of an abnormal pap smear.

31. During the visit of October 15, 2003, Patient E also complained of right nipple discharge.

32. Upon examination during the visit of October 15, 2003, the Respondent noted a mass in Patient E's right breast.

33. The Respondent sent a sample of the bloody nipple discharge to cytology, but she did not order a mammogram or surgical consult for Patient E.

34. Patient E moved to Jamaica several weeks after the October 15, 2003 visit.

35. Patient E developed invasive breast cancer. She was diagnosed in Jamaica, but returned to the United States for some of her care.

36. The Respondent failed to inform Patient E that there was a concern about cancer.

37. The Respondent failed to arrange for a surgical consult within 72 hours.

38. The Respondent failed to meet the standard of care with regard to Patient E.

Patient F

39. Patient F, a forty-two-year old female, had a hysterectomy performed by the Respondent on April 13, 2004.

40. Patient F had a history of pelvic pain and endometriosis.

41. During the surgery, the Respondent noted that Patient F's ovaries were not involved in her endometriosis and, therefore, the Respondent intended to retain Patient F's ovaries.

42. During the course of the surgery, however, the Respondent accidentally removed the left ovary.

43. The Respondent failed to meet the standard of care with regard to Patient F.

LEGAL BASIS FOR PROPOSED RELIEF

A. Pursuant to G.L. c. 112, §5, ninth 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 said physician engaged in conduct which calls into question her competence to practice medicine, including but not limited to practicing medicine with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions.

B. Pursuant to 243 CMR 1.03(5)(a) 17, the Board may discipline a physician upon proof satisfactory to a majority of the Board that said physician is guilty of malpractice within the meaning of M.G.L. c. 112, § 61.

C. Pursuant to 243 CMR 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 of this matter pursuant to G.L c. 112, §§ 5, 61 and 62. This proceeding will be conducted according to the provisions of G.L. c. 30A and 801 CMR 1.01 et seq.

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, in addition to or instead of revocation or suspension, order one or more of the following: admonishment, reprimand, censure, fine, the performance of uncompensated public service, a course of education or training, or other limitation on the Respondent's practice of medicine.

12/17/08 S1 6

ORDER

Wherefore, it is hereby ORDERED that the Respondent show cause why she should not be disciplined for the conduct described herein.

By the
Board of Registration in Medicine,

Date: December 17, 2008

John B Herman MD

John B. Herman, M.D.
Chairman

SENT CERTIFIED MAIL
12/17/08 KJD

COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX, SS.

BOARD OF REGISTRATION
IN MEDICINE

ADJUDICATORY NO.
2008-053

In the Matter of

Elizabeth Darr, M.D.

CONSENT ORDER

Elizabeth Darr, M.D. (the Respondent) and the Complaint Counsel agree that the Board of Registration in Medicine (the Board) may issue this Consent Order with all the force and effect of a Final Decision within the meaning of 801 C.M.R. 1.01(11)(d). The Respondent admits to the findings of fact described below and agrees the Board may make conclusions of law and impose a sanction in resolution of Docket No. 06-618.

BIOGRAPHICAL INFORMATION

1. The Respondent was born on July 1, 1946. She graduated from Tulane University School of Medicine in 1990. The Respondent is board-certified in obstetrics and gynecology. The Respondent has been licensed to practice medicine in Massachusetts under certificate number 214133 since August 21, 2002.

FINDINGS OF FACT

Disciplinary Action

2. On November 22, 2006, Fallon Clinic suspended the Respondent's gynecological surgical privileges. The suspension was imposed due to the Respondent's high surgical complication rate.

3. On March 2, 2007, Fallon Clinic terminated the Respondent's employment for cause.

Patient A

4. Patient A, a thirty-nine-year-old female, had hysterectomy surgery performed by the Respondent on October 23, 2006.

5. During the surgery, the Respondent ligated the right ureter and did not detect it until several days after the surgery.

6. Because of the right ureter ligation, the patient required a prolonged hospital stay and the placement of a nephrostomy tube for urine drainage.

7. The Respondent failed to order a cystoscopy or ask for a urology consult during the procedure to confirm the patency of the ureters.

8. The Respondent failed to meet the standard of care with regard to Patient A.

Patient B

9. Patient B, a forty-seven-year-old female, had hysterectomy surgery performed by the Respondent on March 6, 2006.

10. The pre-operative work-up ordered by the Respondent revealed that Patient B had a platelet count of 87,000.

11. The Respondent proceeded with Patient B's surgery without following up on the platelet count and without consulting with hematology prior to the surgery.

12. Post-operatively, the Respondent ordered Toradol and Motrin for pain relief, both of which can exacerbate bleeding problems.

13. The Respondent did not request a hematology consult post-operatively.

14. On March 14, 2006, Patient B was re-admitted with a pelvic hematoma, a low platelet count, anemia, and severe pain.

15. The Respondent failed to meet the standard of care with regard to Patient B.

Patient C

16. Patient C, a thirty-six-year-old female, had a vaginal hysterectomy surgery performed by the Respondent on August 10, 2004.

17. Patient C was discharged on August 11, 2004.

18. Patient C presented to the Respondent's office on August 19, 2004 complaining of fever and severe pain.

19. The Respondent sent Patient C for an ultrasound at Milford Hospital on that same day.

20. Patient C was subsequently admitted to St. Vincent's Hospital with a diagnosis of peritonitis.

21. Patient C required further surgery and an extended hospital admission.

22. The Respondent's decision to send Patient C for an ultrasound instead of a direct admission was inappropriate.

23. The Respondent failed to meet the standard of care with regard to Patient C.

Patient D

24. Patient D, a fifty-nine-year-old female, had a total abdominal hysterectomy, with removal of both ovaries, performed by the Respondent on August 18, 2006.

25. Patient D had a history of simple cystic endometrial hyperplasia, morbid obesity, hypertension, smoking, and three prior cesarean sections.

26. Patient D was at a very high risk for surgical complications.

27. During the procedure, the Respondent punctured Patient D's bladder and another surgeon was called to repair the bladder.

28. The patient recovered and was discharged from the hospital on August 20, 2006.

29. The Respondent's decision to perform this surgery on Patient D was not appropriate.

Patient E

30. Patient E, a forty-one-year old female, was seen by the Respondent on October 15, 2003 for follow-up of an abnormal pap smear.

31. During the visit of October 15, 2003, Patient E also complained of right nipple discharge.

32. Upon examination during the visit of October 15, 2003, the Respondent noted a mass in Patient E's right breast.

33. The Respondent sent a sample of the bloody nipple discharge to cytology, but she did not order a mammogram or surgical consult for Patient E.

34. Patient E moved to Jamaica several weeks after the October 15, 2003 visit.

35. Patient E developed invasive breast cancer. She was diagnosed in Jamaica, but returned to the United States for some of her care.

36. The Respondent failed to inform Patient E that there was a concern about cancer.

37. The Respondent failed to arrange for a surgical consult within 72 hours.

38. The Respondent failed to meet the standard of care with regard to Patient E.

Patient F

39. Patient F, a forty-two-year old female, had a hysterectomy performed by the Respondent on April 13, 2004.

40. Patient F had a history of pelvic pain and endometriosis.

41. During the surgery, the Respondent noted that Patient F's ovaries were not involved in her endometriosis and, therefore, the Respondent intended to retain Patient F's ovaries.

42. During the course of the surgery, however, the Respondent accidentally removed the left ovary.

12/17/08 15 11

43. The Respondent failed to meet the standard of care with regard to Patient F.

CONCLUSIONS OF LAW

A. The Respondent has violated G.L. c. 112, §5, ninth par. (c) and 243 C.M.R. 1.03(5)(a) 3 in that she engaged in conduct which calls into question her competence to practice medicine, including but not limited to practicing medicine with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions.

B. The Respondent has violated 243 C.M.R 1.03(5)(a) 17 in that she committed malpractice within the meaning of G.L. c. 112, § 61.

C. The Respondent has violated 243 C.M.R. 1.03(5)(a) 18 in that she committed misconduct in the practice of medicine.

SANCTION

Pursuant to G.L. c. 112, § 5A and 243 C.M.R. 1.05(7), the Respondent's license to practice medicine is hereby permanently restricted. The Respondent's license is restricted from: rendering any care to any obstetrical patients who are high-risk; rendering any care to a patient during labor and delivery in any setting; and performing any surgical procedures with the exception of colposcopies and biopsies of the uterine cervix. The Respondent may only provide: routine pre-natal obstetrical care up to 40 weeks gestation; and routine gynecological care.

This sanction is imposed for Conclusions of Law A, B, and C, individually and not for any combination of them.

EXECUTION OF THIS CONSENT ORDER

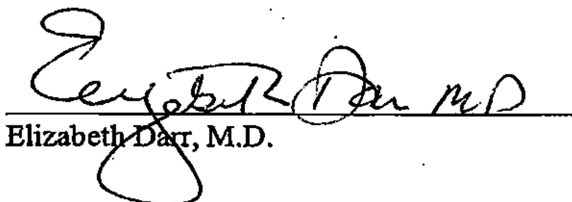
The parties agree that the approval of this Consent Order is left to the discretion of the Board. The signature of the Respondent and Complaint Counsel are expressly conditioned on the Board accepting this Consent Order. If the Board rejects this Consent Order in whole or in

part, then the stipulations contained herein shall be null and void; thereafter neither of the parties nor anyone else may rely on these stipulations in this proceeding. As to any matter that this Consent Order leaves to the discretion of the Board, neither the Respondent, nor anyone acting on her behalf, has received any promises or representations regarding the same.

The Respondent waives any right of appeal that she may have resulting from the Board's acceptance of this Consent Order.

The Respondent shall provide a complete copy of this Consent Order within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which she practices medicine; any in- or out-of-state health maintenance organization with whom she has privileges or any other kind of association; any state agency, in- or out-of-state, with which she has a provider contract; any in- or out-of-state medical employer, whether or not she practices medicine there; the state licensing boards of all states in which she has any kind of license; the Drug Enforcement Administration Boston Diversion Group; and the Massachusetts Department of Public Health Drug Control Program. The Respondent shall also provide this notification to any such designated entities with which she becomes associated following the date of imposition of this permanent license restriction. The Respondent is further directed to certify to the Board within ten (10) days that she has complied with this directive.

The Board expressly reserves the authority to independently notify, at any time, any of the entities designated above, or any other affected entity, of any action it has taken.



Elizabeth Darr, M.D.

Nov 14, 2008

Date

Respondent

David Gould, Esq.
Attorney for Respondent

Date: 11/14/08

Luz A. Carrion, Esquire
Complaint Counsel

Date: 11/19/08

So ordered by the Board of Registration in Medicine this 17th day of December, 2008.

John B. Herman, M.D.
Chairman

SENT CERTIFIED MAIL
12/17/08