

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine  
Adjudicatory No. 2009-039

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In the Matter of	)
	)
Ronald J. Nasif, 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 Ronald J. Nasif, 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 06-486.

**BACKGROUND INFORMATION**

1. The Respondent was born on April 8, 1952. He graduated from Tufts University School of Medicine in 1979. The Respondent's specialty is orthopedic surgery. He is not board-certified. The Respondent has been licensed to practice medicine in Massachusetts under certificate number 46262 since August 1, 1980. The Respondent holds privileges at The Cambridge Health Alliance and Milford Regional Medical Center.

**FACTUAL ALLEGATIONS**

**Patient 1:**

2. Patient 1 was an eighty-nine-year old female who was admitted to Hubbard Regional Hospital on June 21, 2005, after suffering a hip injury from a fall.

3. On June 27, 2005, the Respondent, assisted by another orthopedic surgeon, performed a closed reduction of Patient 1's hip fracture and placed an external fixator device on her hip.
4. Patient 1 was transferred to a rehabilitation facility on July 5, 2005.
5. In Patient 1's discharge summary, the Respondent noted that "With regard to rehabilitation, the physical therapists have been asked to assist her in an effort to improve her range of ambulation. Presently, her fracture remains stable and in excellent position and so she should be allowed to weight bear as tolerated on the right lower extremity."
6. On July 11, 2005, Patient 1 returned to Hubbard's emergency room with significant pain in her hip and bleeding from the pin insertion sites of the fixator device.
7. The Respondent assumed orthopedic care of Patient 1 on July 12, 2005. The Respondent decided to remove the external fixator device and perform an open procedure which would involve an internal fixation of Patient 1's hip.
8. The Respondent left the hospital after Patient 1's surgery was completed and Patient 1 was in stable condition in the Post Anesthesia Care Unit (PACU).
9. Patient 1 subsequently declined and exhibited signs of bleeding.
10. The Respondent was notified at approximately 9:00 p.m. that some bleeding was noted from Patient 1's dressing.
11. In response to a telephone contact after midnight, on July 13, 2005, the Respondent asked the Emergency Department physician to see Patient 1.
12. The Respondent was called again at approximately 1:55 a.m. on July 13, 2005 by the Emergency Department physician and was notified of Patient 1's declining status.
13. The Respondent returned to the hospital at approximately 3 a.m. on July 13, 2005.

14. At about 3:05 a.m., Patient 1 suffered a cardiac arrest, and the Respondent arrived in the ICU as resuscitation attempts were underway.

15. Despite aggressive resuscitation attempts, Patient 1 suffered a secondary cardiac arrest and died at about 6:45 a.m.

16. The Respondent did not clearly document his rationale for his initial decision to perform an external fixator procedure versus an internal fixation surgery or transfer of Patient 1 to a teaching facility.

17. The Respondent deviated from the standard of care in that he had Patient 1 weight bear as tolerated after the external fixator procedure.

Patient 2:

18. Patient 2 was a sixty-year-old male first seen by the Respondent on January 9, 2000 for continued knee pain as a result of a work injury.

19. On March 17, 2000, the Respondent performed an arthroscopy procedure and determined that Patient 2 could benefit from corrective surgery. On that same date, the Respondent performed a high tibial osteotomy procedure.

20. The Respondent's documentation of Patient 2's medical history in the office record was inadequate.

21. There was no clear indication reflected in Patient 2's medical records that he required a tibial osteotomy surgery.

Patient 3:

22. Patient 3 was a fifty-eight-year old male at the time of his left knee injury in August 2001.

23. Patient 3 first saw the Respondent on August 10, 2001 for persistent pain in his knee and inability to bear weight.

24. On January 21, 2002, the Respondent performed a high tibial osteotomy surgical procedure on Patient 3's left knee.

25. The Respondent performed excessive correction of the joint during the surgery.

26. Patient 3 continued to complain of pain after the tibial osteotomy procedure and eventually underwent a total knee replacement by another surgeon.

27. There was no clear indication reflected in Patient 3's medical records that he required a tibial osteotomy surgery.

28. The Respondent deviated from the standard of care in that he performed excessive correction of the joint during the surgery.

Patient 4:

29. Patient 4 was a sixty-eight-year old male at the time he first saw the Respondent on March 13, 2002.

30. Patient 4 had injured his right knee at work and reported having marked tenderness in the medial compartment of the right knee.

31. The Respondent's initial evaluation of Patient 4 was limited with no medical history of the patient obtained.

32. Patient 4's knee x-rays and MRI, did not show osteoarthritic changes.

33. On May 8, 2002, the Respondent performed arthroscopic surgery of the right knee to repair the torn meniscus on Patient 4.

34. On May 8, 2002, the Respondent noted moderate arthritic changes on Patient 4's right knee.

35. On September 20, 2002, the Respondent performed a tibial osteotomy procedure on Patient 4's right knee.

36. During the procedure, the Respondent performed an overcorrection and placed an inadequate fixation on Patient 4's right knee.

37. The Respondent did not clearly document his rationale for proceeding with a tibial osteotomy on Patient 4.

38. The Respondent deviated from the standard of care in that he performed an overcorrection and placed an inadequate fixation on Patient 4's right knee.

Patient 5:

39. Patient 5 was a fifty-one-year old woman who first saw the Respondent in November 2000 for problems with hallux valgus deformities of both feet.

40. The Respondent performed 3 corrective surgeries on Patient 5's right foot and 1 corrective surgery on Patient 5's left foot.

41. The Respondent's medical records for Patient 5 were inadequate.

42. The initial assessment note was limited and did not include a full medical history on Patient 5.

43. Although the Respondent performed corrective surgery on both feet on December 22, 2000, he did not adequately document pre-operatively the condition and assessment of the bilateral foot deformity.

44. The Respondent's medical records for Patient 5 do not indicate whether the Respondent provided Patient 5 with counseling regarding non-operative management of these conditions.

45. Although the Respondent referred to x-rays in Patient 5's medical record, he did not clearly document the angles of the toes and by how much they were out of alignment.

Patient 6:

46. Patient 6 was a thirty-three-year old male who first saw the Respondent in July 2001, following an emergency room visit with complaints of right wrist pain.
47. Patient 6 had a history of a previous fracture of his right radius and x-rays performed at the hospital showed a small bone fragment just beyond the ulnar styloid.
48. The Respondent diagnosed a non-united fracture fragment and recommended surgery to excise this extra bone fragment.
49. During the surgery, the Respondent noted that the tissues of the ulnar styloid appeared to be inflamed and he decided to excise the ulnar styloid.
50. There was indication in Patient 6's medical records that the ulnar injury may have been present for at least 10 or 15 years prior to Patient 6 seeing the Respondent.
51. The Respondent's medical records for Patient 6 were inadequate.
52. The initial examination of Patient 6 on July 20, 2001 was focused only on his wrist pain and the Respondent did not document any preceding trauma or a medical history.
53. There was no clear indication documented for Patient 6's surgery.

LEGAL BASIS FOR PROPOSED RELIEF

A. Pursuant to G.L. c. 112, §5, ninth par. (c) and 243 C.M.R. 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 his competence to practice medicine, including but not limited to negligence on repeated occasions.

B. Pursuant to 243 C.M.R. 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 G.L. c. 112, § 61.

C. Pursuant to G.L. c. 112, §5, ninth par. (h) and 243 C.M.R. 1.03(5)(a) 11, the Board may discipline a physician upon proof satisfactory to a majority of the Board that said physician violated a rule or regulation of the Board.

1. Pursuant to 243 C.M.R. 2.07(13), a physician shall maintain a medical record for each patient that is adequate to enable the physician to provide proper diagnosis and treatment.

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 C.M.R. 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.

ORDER

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

By the  
Board of Registration in Medicine,

Date: December 16, 2009

  
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Peter G. Paige, M.D.  
Chairman



5. In Patient 1's discharge summary, the Respondent noted that "With regard to rehabilitation, the physical therapists have been asked to assist her in an effort to improve her range of ambulation. Presently, her fracture remains stable and in excellent position and so she should be allowed to weight bear as tolerated on the right lower extremity."
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13. The Respondent returned to the hospital at approximately 3 a.m. on July 13, 2005.
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15. Despite aggressive resuscitation attempts, Patient 1 suffered a secondary cardiac arrest and died at about 6:45 a.m.

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41. The Respondent's medical records for Patient 5 were inadequate.
42. The initial assessment note was limited and did not include a full medical history on Patient 5.
43. Although the Respondent performed corrective surgery on both feet on December 22, 2000, he did not adequately document pre-operatively the condition and assessment of the bilateral foot deformity.
44. The Respondent's medical records for Patient 5 do not indicate whether the Respondent provided Patient 5 with counseling regarding non-operative management of these conditions.
45. Although the Respondent referred to x-rays in Patient 5's medical record, he did not clearly document the angles of the toes and by how much they were out of alignment.

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50. There was indication in Patient 6's medical records that the ulnar injury may have been present for at least 10 or 15 years prior to Patient 6 seeing the Respondent.
51. The Respondent's medical records for Patient 6 were inadequate.
52. The initial examination of Patient 6 on July 20, 2001 was focused only on his wrist pain and the Respondent did not document any preceding trauma or a medical history.
53. There was no clear indication documented for Patient 6's surgery.

### **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 he engaged in conduct which calls into question his competence to practice medicine, including but not limited to negligence on repeated occasions.
- B. The Respondent has violated 243 C.M.R. 1.03(5)(a) 17 in that he committed malpractice within the meaning of G.L. c. 112, § 61.
- C. Respondent has violated G.L. c. 112, §5, ninth par. (h) and 243 C.M.R. 1.03(5)(a) 11 in that he violated a rule or regulation of the Board.
1. The Respondent has violated 243 C.M.R. 2.07(13) by not-maintaining a medical record for each patient that is adequate to enable the physician to provide proper diagnosis and treatment.

### **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 shall not perform tibial osteotomies or external fixation procedures of the hip.

In addition, the Respondent must take five (5) category 1 CME credits in documentation in addition to those required for the renewal of his license. The Respondent shall provide documentation to the Board of the CME credits within six months of approval of the Consent Order.

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

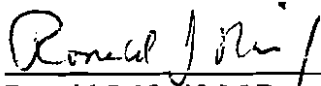
### **EXECUTION OF THIS CONSENT ORDER**

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 Complaint Counsel, the Respondent or anyone else may not 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 his behalf, has received any promises or representations regarding the same.


The Respondent waives any right of appeal that he 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 he practices medicine; any in- or out-of-state health maintenance organization with whom he has privileges or any other kind of association; any state agency, in- or out-of-state, with which he has a provider contract; any in- or out-of-state medical employer, whether or not he practices medicine there; the state licensing boards of all states in which he 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 he 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 he has complied with this directive.

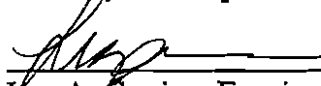
The Board expressly reserves the authority to independently notify, at any time, any of the entities designated above, or any other affected entity, of any action it has taken.

  
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Ronald J. Nasif, M.D.  
Respondent

16 Nov 09  
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Date

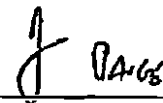
  
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Paul McTague, Esq.  
Attorney for Respondent

11/16/09  
\_\_\_\_\_  
Date

  
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Luz A. Carrion, Esquire  
Complaint Counsel

11/19/09  
\_\_\_\_\_  
Date

So ordered by the Board of Registration in Medicine this 16 day of December, 2009.

  
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Peter G. Paige, M.D.  
Chairman