STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

BOARD OF MEDICINE

In Re: Richard Caesar, MD
Med. License #15402

Docket No.: ~~22-MED-001~~ 22-MED-004 CE

FINAL DECISION—04/06/22

I. ATTENDEES:

David Conway, Board President
Nina Gardner, Board Member
Emily Baker, Board Member
Richard Kardell, Board Member
Jonathan Ballard, Board Member
David Goldberg, Board Member
Susan Finerty, Board Member
Linda Tatarczuch, Board Member
Nikolas Frye, Presiding Officer
Richard Caesar, Licensee (via Zoom)
Christine Senko, Supervising Administrator
Jessica Kennedy, Board Administrator
Attorney Michael Haley, Board Counsel

II. CASE SUMMARY/PROCEDURAL HISTORY:

On or about 12/01/21, the Board of Medicine ("Board") voted unanimously by roll call to issue a Notice of Hearing to Dr. Richard Caesar ("Licensee") for a show cause hearing. The purpose of the hearing was to learn why reciprocal action should not be taken in New Hampshire in relation to the disciplinary action taken by another state licensing board against Licensee. A final adjudicative hearing was held on 04/06/22. Pursuant to N.H. Code Admin. R. Med 207.01(b) ("Rules"), Nikolas Frye, Esq., (Hearings Examiner) was appointed as presiding officer. This final order follows.

III. SUMMARY OF THE EVIDENCE:

The Board received the following evidence pursuant to RSA 541-A:33 and Rule 206.09:

a. Exhibits were submitted by the Board, numbered as follows:

1. State of Maine Board of Licensure in Medicine Consent Agreement In re: Richard Evan Caesar, M.D., Complaint No CR20-86, dated 11/09/21;

2. Email Correspondence from Licensee and others, dated 11/10/21.

b. Licensee submitted no additional Exhibits.

c. Testimony from Licensee

IV. CONDUCT OF THE HEARING AND EVIDENCE PRESENTED:

After receiving the Consent Agreement from the Licensee and reviewing the same, the Board conducted this adjudicative disciplinary hearing pursuant to RSA 329:17-c. At his request, Licensee appeared via Zoom. Pursuant to RSA 329:17-c and Rule 410.01, the Board may issue any disciplinary sanction or take any action regarding the Licensee otherwise permitted under RSA 329:17(VII), including sanctions or actions that are more stringent than those imposed by the foreign jurisdiction. Licensee can also demonstrate, by a preponderance of the evidence, why a lesser sanction should be imposed instead. *See* Rules 206.10(a) *and* 410.01(a).

The credible evidence presented at the hearing allows the Board to find the following facts. Licensee currently holds New Hampshire Physician's License #15402, which is active now and was active during the year 2019. On 11/09/21 the State of Maine Board of Licensure in Medicine ("Maine Board") approved a Consent Agreement involving the Licensee, in which it reprimanded him for unprofessional conduct for violation of an applicable standard of care and ordered him to work with a Maine Board preapproved "Surgical Proctor" for a period of probation of not less than six months. Exhibit 1. The Surgical Proctor is to provide bi-monthly written reports to the Maine Board and provide a recommendation on whether further proctoring is required after submitting his or her third written

report. *Id.* The basis of the Consent Agreement were two incidents involving two separate patients. *Id.* With respect to the first, Licensee allegedly placed in a patient a ureteral stent that had been dropped on the operating room floor. *Id.* The second incident involved the Licensee allegedly failing to timely recognize the significance of the volume of fluid being irrigated during an endoscopic procedure lasting 4 hours. *Id.* That patient was later transferred to another hospital where he was treated with a laparotomy and his ruptured bladder wall was repaired. *Id.*

After being sworn in under oath, the Licensee provided testimony on the factual allegations of misconduct that resulted in the Consent Agreement. He explained that the first allegation of misconduct occurred at a small hospital in northern Maine in 2019. He clarified that the case involved a stone obstruction of the patient's left kidney, who was quite tall and required a 28 mm stent. He explained that the stent was accidentally dropped on the floor during the procedure and unfortunately there were no other appropriately sized stents to use. The Licensee admitted he decided to sanitize the stent that had fallen on the ground and use it. He described his decision as a "mistake" and not up to the standard of care. He reflected that he had another option of keeping the patient overnight and, upon Board questioning, acknowledged this is what he should have done and will do in the future. He also stated that he learned he should have checked to discover whether there was a full inventory of stents before performing the surgery.

The Licensee next testified to the second incident, which occurred at the same hospital in 2019 and involved a 75-year old man. The patient had a bladder filled with a clot and a very large prostate with no tumors. Consequently, during the procedure, Licensee decided to irrigate the bladder but could not get the clot out. There was an abdominal distension of which Licensee was unaware. The Licensee had placed a tube in to evacuate the bladder but could not tell if there was perforation. A CAT scan later confirmed there was. The patient was transferred to a larger hospital where his bladder was closed and he ultimately was fine. The Licensee admitted that not noticing the bladder perforation was not up to

the standard of care.

Licensee closed by explaining that he currently has a Surgical Proctor monitoring all his cases. He explained that he has had multiple other reciprocal discipline hearings on this matter. Indiana has placed him on probation, Massachusetts is deferring a decision to see what the Maine Board does upon recommendation by the Surgical Proctor, and Florida has scheduled a hearing, but nothing substantively has occurred. During further Board questioning, Licensee stated he was not contesting the Maine discipline. He offered he was following Maine's recommendation and happy to have the Board contact his Surgical Proctor supervisor or obtain his or her reports. He closed by stating he does not currently practice in New Hampshire but has done so in the past in Laconia and may look to do so in the future.

V. DISCUSSION AND FINDINGS OF FACTS / CONCLUSIONS OF LAW:

After reviewing all the evidence, and accounting for the credibility and demeanor of the witness, the Board finds, by a preponderance of the evidence, that the Respondent has committed misconduct. The central facts in this case are clear and undisputed: both Licensee's use of the stent on the first patient after it fell on the floor and him not recognizing the abdominal distension with respect the second patient fell below the standard of care. The Board ultimately concludes that instituting reciprocal discipline is appropriate in this matter. As part of this decision, the Board makes the following findings of fact and conclusions of law:

A. In 2019, Licensee was a physician, licensed through the inter-state compact in the State of New Hampshire.

B. On or about 11/10/21, the Board received from the Licensee "State of Maine Board of Licensure in Medicine Consent Agreement In re: Richard Evan Caesar, M.D., Complaint No CR20-86, dated 11/09/21", reprimanding Licensee and subjecting him to further discipline for the same alleged transaction or occurrence, namely supervision by a Surgical Proctor.

C. Pursuant to RSA 329:17-c, Licensee was given the opportunity to appear and show cause why similar disciplinary sanctions should not be imposed by the Board. Licensee appeared via Zoom and indicated he was not seeking to have the Board provide less discipline than Maine had.

D. Pursuant to RSA 329:17(VI)(c) and/or RSA 329:17(VI(d), Licensee has committed professional misconduct by using the stent that fell on the ground in the first patient and failing to recognize the abdominal distension occurring in the second patient, as noted herein.

E. Pursuant to RSA 329:17-c and RSA 329:17(VII)(a), and upon a finding of professional misconduct under section RSA 329:17(VI), the Board orders that Licensee is hereby reprimanded.

F. Pursuant to RSA 329:17-c and RSA 329:17(VII)(f), and upon a finding of professional misconduct under section RSA 329:17(VI), the Board orders that Licensee is to work with a Surgical Proctor in the manner set forth in Paragraph 7, b) of the State of Maine Board of Licensure in Medicine Consent Agreement In re: Richard Evan Caesar, M.D., Complaint No CR20-86, dated 11/09/21. **As part of this discipline, the Licensee shall ensure this Board is timely provided with the Surgical Proctor's reports and recommendations as contemplated under Paragraph 7, b) of the Consent Agreement.**

G. Pursuant to RSA 329:24(III)(b) and Rules 408.03 and 411.02, and upon a finding of professional misconduct, the Board finds that the above-referenced reprimand and supervision program is appropriate and is the minimum sanction required in order to punish and/or deter said conduct. The Board considered the following factors in coming to this conclusion: 1) seriousness of the offense; (2) the licensee's prior disciplinary record; (3) The licensee's state of mind at the time of the offense; (4) The licensee's acknowledgment of his or her wrongdoing; (5) The licensee's willingness to cooperate with the board's investigation; (6) The purpose of the rule or statute violated; (7) The potential harm to public health and safety; (8) The deterrent effect upon other practitioners; and (9) The nature and extent of the enforcement activities required of the board as a result of the offense. Based upon those factors it determined that the discipline imposed by the State of Maine is appropriate in New Hampshire.

VI. CONCLUSION AND DECISION:

Pursuant to RSA 329:17-c and RSA 329:17, the Board hereby orders that Licensee be REPRIMANDED, and subjects him to further discipline as outlined above.

DATED:
4/14/2022

___/s/ Nikolas Frye, Esq._____
Nikolas Frye, Esq., Hearings Examiner
Authorized Representative of the
Board of Medicine-
New Hampshire Office of
Professional Licensure & Certification
7 Eagle Square
Concord, NH 03301