

State of Rhode Island
Department of Health
Board of Medical Licensure & Discipline



IN THE MATTER OF:
Charles Mark Rosenthal, MD
License No.: MD 07123
Case No.: C181582

CONSENT ORDER

Charles Mark Rosenthal, MD (“Respondent”) is licensed as a physician in Rhode Island. The Rhode Island Board of Medical Licensure and Discipline (“Board”) has reviewed and investigated the above-referenced complaint pertaining to Respondent through its Investigative Committee. The Board makes the following

FINDINGS OF FACT

1. Respondent has been a licensed physician in the State of Rhode Island since July 1, 1987. Respondent graduated from Cornell University Medical College in 1981.
2. The Board received a complaint from the Rhode Island Department of Health (“RIDOH”) Center for Health Facilities Regulation regarding Respondent’s review of a Computed Tomography (“CT”) scan.
3. On March 20, 2018, Patient A (alias), was transported by ambulance to the Landmark Medical Center emergency department because of acute abdominal pain. The emergency department physician ordered an abdominal/pelvic scan with intravenous contrast, which was performed that day.

4. Respondent was the radiologist assigned to review Patient A's CT scan. In the report, Respondent documented the identification of a large, right, renal cyst and a distended gallbladder. The initial report did not document the identification of any urgent or emergent conditions.

5. Subsequent to Respondent's initial interpretation of the CT scan, Patient A was discharged home, but returned to the emergency department less than 24 hours later with increased pain. Upon Patient A's return, a surgeon was consulted. The surgeon reviewed Patient A's March 20, 2018 CT scan with Respondent and both the surgeon and Respondent identified the presence of free-air in the abdomen on the CT scan, which had been missed on Respondent's initial read. The presence of free air detected on a CT scan is a critical finding. Respondent added an addendum to the report with the additional finding, as per established hospital protocol to correct the medical record. .

6. The Board consulted with an expert who reviewed Patient A's CT scan and concluded that the CT scan showed free air, which should have been detected pursuant to the initial read. The expert concluded that in failing to detect the presence of free air the standard of care was not met.

7. Respondent appeared before the Investigative Committee on September 3, 2020, at which appearance Respondent explained that he is not sure why the critical finding was not identified, although one of the possibilities was that a computer error, that had happened previously, may have occurred, resulting in the report being finalized and closed without his knowledge. Respondent explained that in this possible scenario, he would have been interrupted during his initial review of Patient A's CT scan and that his report was closed and electronically signed by the computer prior to his concluding his formal review of the templated report.

8. The Investigative Committee concluded Respondent that Respondent violated R.I. Gen. Laws § 5-37-5.1(19), which defines “unprofessional conduct” as including “any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice in his or her area of expertise as is determined by the board.”

Based on the foregoing, the parties agree as follows:

1. Respondent admits to and agrees to remain under the jurisdiction of the Board.
2. Respondent has agreed to enter into this Consent Order and understands that it is subject to final approval of the Board and is not binding on Respondent until final ratification by the Board.
3. If ratified by the Board, 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 on 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 those specifically contained herein;
 - f. Any and all rights of appeal of this Consent Order;
 - g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review; and
 - h. Any objection to the fact that this Consent Order will be reported to the National Practitioner Data Bank and Federation of State Medical Boards and posted to the Rhode Island Department of Health (“RIDOH”) public website.
4. Respondent agrees to pay, within 5 days of the ratification of this Consent Order, an administrative fee of \$1100.00 for costs associated with investigating the above-referenced

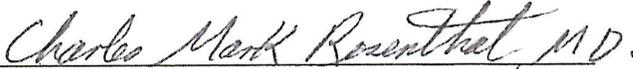
complaint. Such payment shall be made by certified check, made payable to “**Rhode Island General Treasurer,**” and sent to Rhode Island Department of Health, 3 Capitol Hill, Room 205, Providence, RI 02908, Attn: Lauren Lasso. Respondent will send notice of compliance with this condition to DOH.PRCCompliance@health.ri.gov within 30 days of submitting the above-referenced payment.

5. Respondent hereby agrees to this reprimand on his physician license.

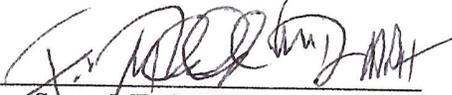
6. Within 6 months of the ratification of this Consent Order, Respondent shall, at his own expense, complete a minimum of 8 hours of Board-approved CME courses in emergent conditions in Radiology. Respondent will send notice of completion to DOH.PRCCompliance@health.ri.gov within 30 days of satisfying this requirement.

7. In the event that any term of this Consent Order is violated after ratification by the Board, the Director of RIDOH (“Director”) shall have the discretion to impose further disciplinary action. If the Director imposes further disciplinary action, Respondent shall be given notice and shall have 20 days from the date of the suspension and/or further discipline to request an administrative hearing. The Director shall also have the discretion to request an administrative hearing after notice to Respondent of a violation of any term of this Consent Order. The Administrative Hearing Officer may suspend Respondent’s license, or impose further discipline, for the remainder of Respondent’s licensing period if the alleged violation is proven by a preponderance of evidence.

Signed this 3rd day of OCTOBER, 2020.


Charles Mark Rosenthal, MD

Ratified by the Board of Medical Licensure and Discipline on the 14th day of October,
2020.



Nicole Alexander-Scott, MD, MPH
Director
Rhode Island Department of Health
3 Capitol Hill, Room 401
Providence, RI 02908



James V. McDonnell MD MPH