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

IN THE MATTER OF:
Michael P. Bradley, MD
License No.: MD 12098
Complaint Nos.: 171778, 190449A, 181383

CONSENT ORDER

The Rhode Island Board of Medical Licensure and Discipline ("Board") has reviewed and investigated the above-referenced complaints pertaining to Dr. Michael P. Bradley ("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 May 16, 2006. Respondent's office is located at 1 High Street, Wakefield, RI. His primary specialty is Orthopedics.

2. Respondent was the attending physician for Patient A (alias).

3. Patient A was a 69-year-old female who sustained a displaced right femoral neck (hip) fracture.

4. Complaint 171778 was reported to the Board by Patient A's spouse ("Complainant"); however, Patient A did not, herself, file a complaint or provide a statement to the Board, and neither Complainant nor Patient A would agree to meet with the Investigative Committee or Respondent.

5. Patient A fell on February 29, 2016. Respondent had orthopedic coverage for the

Emergency Department at Newport Hospital. Respondent evaluated Patient A and performed a right hip arthroplasty (hip replacement) later that day using a short stem, press fit femoral implant that was and remains one of the recommended approaches for treating Patient A's fracture. The surgery was completed without complication, and Patient A was admitted to Newport Hospital, with the plan of being transferred to Vanderbilt Rehabilitation Center for her recovery from the hip surgery.

6. Patient A was seen twice by Respondent's orthopedic physician assistant while in Newport Hospital before being transferred on post-operative day (POD) #2 to the Vanderbilt Rehabilitation Center ("Vanderbilt"), which, albeit within Newport Hospital, is nevertheless a different facility from Newport Hospital, where Patient A came under the care of the Vanderbilt staff, who specialize in caring for patients such as Patient A.

7. On POD #9, while Patient A was in Vanderbilt, a pathology report came back suspicious for multiple myeloma. The nurse practitioner managing Patient A informed Patient A of the finding and had the oncologist see Patient A that same day to discuss the findings and her options.

8. Patient A was not able to make her initial follow up visit with Respondent because of her recent diagnosis and subsequent readmission to Newport Hospital on POD #29 for urosepsis unrelated to the hip surgery.

9. Patient A sought a second opinion at Massachusetts General Hospital ("Mass General") on POD #35, but never allowed Mass General to convey any of their information to Respondent. At Mass General, Patient A was evaluated by orthopedics and a specialist in multiple myeloma. Patient A was started on treatment for multiple myeloma and was discharged four days later. The orthopedic consultation at Mass General included a CT scan that revealed a healing,

comminuted, periprosthetic fracture of Patient A's right femur.

10. The Board retained a physician to review the facts and circumstances of complaint 171778. The physician opined that he believed that cemented fixation would have provided immediate fixation, stabilization and pain relief, that "*the femoral component chosen in this case was ill-suited and inappropriate based on the clinical concern for fracture due to an underlying pathologic process*," and that the standard of care was not met. Respondent strongly disagreed with that opinion, as there are at least two well-recognized approaches to treating this condition and cementing in this situation runs the risk of serious adverse reaction. Moreover, the implant selected successfully repaired the fractured hip.

11. The Board received complaint 190449A relative to Respondent's care of Patient B, a 64-year-old female, who suffered complications following total hip replacement performed by Respondent. Patient B disputed whether a subsequent post-operative infection that did not manifest itself for eight-weeks post-op was timely identified and treated and she disputed the documentation in her outpatient medical record, feeling it did not accurately reflect her post-operative course.

12. Respondent was the attending physician for Patient B and he had a prior existing relationship with her, having successfully performed shoulder surgery upon her in the past.

13. Respondent performed a left, total hip arthroplasty on Patient B on August 8, 2018. Patient B presented to Respondent on multiple occasions post-operatively complaining of persistent pain. When Respondent determined Patient B was not progressing, he referred her to another orthopedic surgeon for care and called to get her in to be seen within two to three days. [The records of the subsequent treating orthopedic surgeon have not been made available to the Board or the Respondent.]

14. Patient B was adamant she was in severe pain from her left hip and was insisting on surgery. In an effort to accommodate Patient B, Respondent provided Patient B his cell phone number for direct access to him for any issues she may have. Respondent authorized cortisone steroid injections, which provided brief pain relief, but were followed by Patient B insisting on the Respondent performing surgery to relieve her excruciating hip pain, as evidenced by her text message exchange with Respondent.

15. The Board retained the same physician referenced above to opine on Respondent's care of Patient B. The physician noted that Patient B had a well-documented, difficult, post-operative recovery. Nevertheless, the physician felt that Respondent's clinical assessment of Patient B was discrepant from Patient B's documented chief complaints. Additionally, the physician surmised that Patient B had a loose acetabular component, which would explain her slow recovery. He felt that this should have prompted Respondent to evaluate Patient B for infection earlier. The physician also opined that the cortisone injection so close to the date of surgery may have increased her risk of post-operative infection.

16. The Board determined that Respondent should have suspected a possible infection and/or referred Patient B to another orthopedic surgeon for a second opinion sooner. The Investigative Committee found that there was a delay of a week or two in diagnosing and treating the presumptive infection of the artificial hip.

17. Complaint 181383 involved Patient C, for whom Respondent was the attending physician.

18. The Board found that Respondent or his physician assistant prescribed pain medications that were controlled substances, specifically opioids, to Patients A, B and C for post-operative pain. The Board found that Respondent did not educate these patients about the risk of

dependence, co-ingestion with other sedating medications, safe storage and proper disposal as required by the applicable regulations. However, there was neither a complaint about nor any evidence that any problem or issue arose regarding these medications, and there was neither a complaint about nor any evidence that the medications were prescribed in any manner other than the proper type, dosage, and duration. Similarly, there was neither a complaint about nor any evidence of any adverse reactions to the medication prescribed.

19. The Board found that Respondent has undertaken substantial remediation regarding controlled substance prescribing and demonstrated leadership in his practice by implementing a protocol, "Opioid Reduction Pathway." Additionally, Respondent has implemented protocols for non-narcotic treatment of acute pain regarding orthopedic injuries, which further reduces the number of patients exposed to opioids.

20. Respondent has been using a "scribe" during all office visits since January 2019 to ensure comprehensive documentation.

21. Respondent violated R.I. Gen. Laws § 5-37.5.1(19), Section 4.4(D) of the Rules and Regulations for Pain Management, Opioid Use and the Registration of Distributors of Controlled Substances in Rhode Island (216-RICR-20-20-4), relative to "Patient Education/ Informed Consent," and Section 1.5.12(D) of the Rules and Regulations for the Licensure and Discipline of Physicians (216-RICR-40-05-1), relative to "Medical Records."

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 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 that this Consent Order will be reported to the National Practitioner Date Bank and Federation of State Medical Boards and posted to the RIDOH public website.

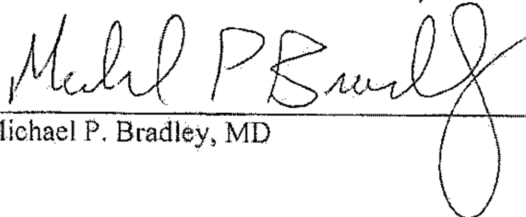
4. Respondent agrees to pay, upon ratification of this Consent Order, an administrative fee of $5653.67 for costs associated with investigating the above-referenced complaints. Such payment shall be made by certified check, made payable to the **"Rhode Island General Treasurer,"** and sent to Island 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.PRCompliance@health.ri.gov within 5 days of submitting the above-referenced payment.

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

6. Respondent shall take, at his own expense, a Board-approved CME in medical records, such as the Case Western Reserve University Intensive Course in Medical Documentation, to be completed within ten months of the ratification of this Consent Order. Respondent will send notice of compliance with this condition to DOH.PRCompliance@health.ri.gov within 30 days of completing this course.

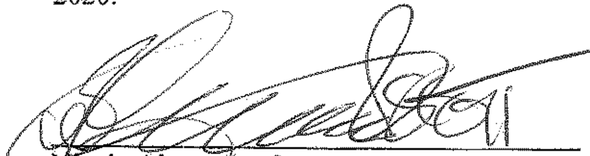
7. In the event that any material term of this Consent Order is violated, after it is signed and accepted, the director of RIDOH ("Director") shall have the discretion to impose further disciplinary action. If the Director imposes further disciplinary action, Respondent shall be given notice and shall have the right to request an administrative hearing within 30 days of the suspension and/or further discipline. The Director shall also have the discretion to request an administrative hearing after notice to Respondent of a violation of any material term of this Consent Order. The Board 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 6th day of February, 2020.



Michael P. Bradley, MD

Ratified by the Board of Medical Licensure and Discipline on the 12th day of February 2020.



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