

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



**IN THE MATTER OF:**  
**Robert McRae M.D.**  
**License Number MD 05604**  
**Case # 180516**

**CONSENT ORDER**

Robert McRae, M.D. (hereinafter "Respondent") is licensed as a physician in Rhode Island. The Board of Medical Licensure and Discipline (hereinafter the "Board") makes the following:

**FINDINGS OF FACT**

1. Respondent has been a licensed physician in the State of Rhode Island since December 12<sup>th</sup>, 1979. He is a graduate of Tufts University on May 16<sup>th</sup>, 1976. His primary specialty is Otolaryngology. He is Board certified. His practice is located at University Otolaryngology, 830 Eddy Street, Providence, Rhode Island.
2. The Board received a complaint alleging the documentation regarding the care delivered to Patient A (alias) in the post-operative medical record was inaccurate, substandard and completed prior to the surgical procedure.
3. Respondent was the attending physician for Patient A, who was a 24-year-old female who had a tonsillectomy December 9<sup>th</sup>, 2014.
4. Patient A died in her home on post-operative day number 2.
5. An autopsy was performed on Patient A on December 15<sup>th</sup>, 2014 by the state medical examiner. The cause of death was determined to be due to hemoaspiration and exsanguination.
6. There was a pre-operative physical completed for Patient A which is undated, which

states the indication for the procedure was chronic tonsillitis. The section of the pre-operative physical indicating present history is illegible. The physical exam indicates normal in all sections and there are sections of this note in the physical that are illegible. There is an illegible signature at the bottom of the page, yet no other indication of the identity of the treating physician.

7. The post-operative note indicates Patient A had no complications and the tonsils were removed by use of coblation. There is an indication the blood loss was minimal, which was crossed out multiple times and 500 cc is indicated instead. There is no indication what day or time the word minimal was crossed out on the post-operative note.
8. Respondent provided a written response, and subsequently appeared before the investigative committee on October 31, 2018. Respondent admitted it was his usual practice to complete portions of his surgical notes prior to surgery, and that he completed portions of the post-operative note regarding Patient A before the surgery was completed. Respondent noted that he wrote 500 cc blood loss on the operative note prior to exiting the operating room on the day of surgery. Respondent admitted during the October 31<sup>st</sup>, 2018 appearance he no longer completed his post-operative notes prior to surgery.
9. Respondent also admitted he placed an orogastric tube to empty Patient A's stomach from blood, which caused a small midline laceration that was surgically repaired. Respondent did not consider the midline laceration or the surgical repair thereof to be a complication, and did not indicate either as a complication in the post-operative medical record.
10. The Investigative Committee concluded Respondent's documentation did not meet the standard of care. Specifically, Respondent's documentation was substantially completed prior to the surgical procedure. Respondent did not completely document the post-operative report and did not completely identify the techniques utilized to surgically remove the tonsils, specifically using the Bovie electrocautery. Respondent did not report the midline laceration as a complication, or, the insertion of the OG tube. The Respondent did not comment on the significance, if any of the 500 cc blood loss. The Investigative committee also noted there was no legible indication who authored this post-operative and pre-operative note. Also, the pre-operative record had sections of the

note that were illegible. The committee also found that the pre-operative note did not clearly document why the patient was to undergo the planned surgical procedure.


11. Respondent has violated Rhode Island General Laws, specifically, § 5-37-5.1 (19) *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* as it related to documentation. The Board also alleges Respondent's documentation violated Rules and Regulations for the Licensure and Discipline of Physicians 11.4 *Medical Records shall be legible and contain the identity of the physician who is responsible for rendering, ordering, supervising or billing each diagnostic or treatment procedure. The records must contain sufficient information to justify the course of treatment, including, but not limited to: active problem and medication lists; patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consults and hospitalizations.*

**Based on the foregoing, the parties agree as follows:**

1. Respondent admits to 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 this Consent Order 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; and
  - g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review.

- h. Any objection that this Consent Order will be reported to the National Practitioner Data Bank, Federation of State Medical Boards as well as posted on the department's public web site.
4. Respondent agrees to pay within (60) days of the ratification of this Consent Order an administrative fee to the Board with a check for \$1050 dollars made payable to the Rhode Island General Treasurer for costs associated with investigating the above-referenced complaint.
  5. Respondent hereby agrees to this reprimand on his physician license.
  6. Respondent agrees to take within six (6) months of the ratification of this order a Board approved CME of at least 20 hours duration regarding medical records.
  7. Respondent shall send evidence of completing the course to [DOH.PRCCompliance@health.ri.gov](mailto:DOH.PRCCompliance@health.ri.gov) no later than the 15<sup>th</sup> calendar day of the immediate following month.
  8. In the event that any term of this Consent Order is violated, after it is signed and accepted, the Director of the Department of Health 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 twenty (20) days of the suspension and/or further discipline. The Director of the Department of Health 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 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 11 day of December, 2018.

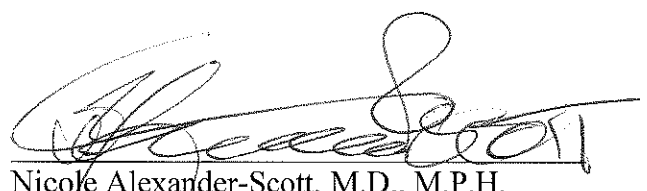


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Robert McRae, M.D.

Ratified by the Board of Medical Licensure and Discipline on the 9<sup>th</sup> day of

January 201~~8~~<sup>9</sup>  
NAS



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