VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: BENJAMIN F. ALLEN, M.D.
License No.: 0101-031146

ORDER

In accordance with Sections 54.1-2400(10), 2.2-4019, and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), an informal conference was held with Benjamin F. Allen, M.D., on January 16, 2013, in Henrico, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the Special Conference Committee ("Committee") were: Sandra Anderson Bell, M.D., Chair; Claudette Dalton, M.D.; and Wayne Reynolds, D.O. Dr. Allen appeared personally and was not represented by legal counsel. Tracy E. Robinson, Adjudication Specialist, was present as a representative for the Administrative Proceedings Division of the Department of Health Professions.

The purpose of the informal conference was to inquire into allegations that Dr. Allen may have violated certain laws and regulations governing the practice of medicine in the Commonwealth of Virginia, as set forth in a Notice of Informal Conference dated December 5, 2012.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Now, having properly considered the evidence and statements presented, the Committee makes the following Findings of Fact and Conclusions of Law:

1. Benjamin F. Allen, M.D., was issued license number 0101-031146 by the Board to practice medicine and surgery in the Commonwealth of Virginia on September 18, 1979. Said license is currently active and will expire on March 31, 2014, unless renewed or

otherwise restricted.

2. Dr. Allen violated Sections 54.1-2915.A(12) and (18) of the Code and 18 VAC 85-20-29.A(2) of the Board of Medicine General Regulations by engaging in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient, as follows:

a. On or about March 20, 2012, after Dr. Allen had performed a total knee replacement on Patient A, as a "joke" he arranged with hospital staff to have Patient A placed on the operating room schedule for revision knee surgery to take place on or about March 22, 2012. Several members of hospital staff were unaware of the "joke" and staff prepared the operating room for the scheduled surgery. Additionally, the patient learned that she had been scheduled for revision surgery and was upset until Dr. Allen spoke with her. Moreover, at least one other surgeon requested time in the operating room on the day Dr. Allen had scheduled the "joke" surgery, but was denied due to the surgery that Dr. Allen had scheduled for Patient A.

b. On or about April 5, 2012, during Dr. Allen's care and treatment of Patient B:

i. Dr. Allen became involved in a loud argument with an anesthesiologist in the operating room while two other anesthesiologists were preparing Patient B for hip surgery. Patient B was conscious at the time of the argument. Hospital administration eventually intervened in the

argument. Following this incident, one of the anesthesiologists refused to work with Dr. Allen in the future.

ii. Following the incident described above, Patient B experienced a hypotensive event during the administration of anesthesia and her surgery was cancelled. After the patient was stabilized, she was taken to the ICU for monitoring. Later that day, Dr. Allen rescheduled Patient B for hip surgery without first determining whether the patient had been cleared by anesthesiology.

c. Since 2009, Dr. Allen has engaged in the following behaviors at a hospital at which he has privileges:

i. By Dr. Allen's own admission, following a procedure in the operating room, he stapled the forearm of a nurse while attempting to staple her gown sleeve. After the incident, the nurse followed the employee protocol for blood exposure from the staple gun, as the staple gun had just been used on a patient. Dr. Allen stated to the Board's investigator that the staple gun had been malfunctioning and he was attempting to test it, but others described the incident as a "joke" or stated that Dr. Allen had been "playing around" when he stapled the nurse's arm.

ii. At a surgical section meeting at the hospital, Dr. Allen berated several podiatrists during a discussion of whether the podiatrists should begin taking call from the emergency room for foot and ankle injuries. During

the meeting, at which the podiatrists were present, Dr. Allen reportedly stated, "Leave the surgery to the real doctors."

iii. During a visit by a mock surveyor who was preparing hospital staff for an upcoming real survey, Dr. Allen refused to cooperate with a "time out" that is part of the pre-operative protocol.

3. Dr. Athar, the anesthesiologist identified in Finding of Fact #2b, testified on Dr. Allen's behalf. Dr. Athar explained that the incident on April 5, 2012, came about because Dr. Allen believed the patient was clear for surgery since the hospitalist had optimized the patient for sodium and cleared the patient from the floor. However, Dr. Athar stated that the patient had not been cleared by anesthesia for surgery due to a lack of volume. Dr. Athar stated that after this incident they put a process in place that better defines the endpoints for the hospitalists, so they know how to ensure the patients are optimized appropriately to achieve clearance by anesthesia.

4. Dr. Athar said that since this event, he has seen positive changes in the hospital process and system, and in Dr. Allen. He noted that none of these types of events occur in a vacuum or because of one individual, and that usually they are brought about by multiple factors. He noted Dr. Allen has been an exemplary figure in his many leadership roles at the hospital, including leading the implementation of electronic record-keeping at the hospital, and the time-out process in the operating room. Dr. Athar emphasized that Dr. Allen is a great surgeon and his patients love him and he is an asset to the hospital and the community. He noted if he or his family needed orthopedic surgery, he would seek surgical care from Dr. Allen.

5. For the past two years, Dr. Allen's behavior has been monitored by the hospital pursuant to their zero-tolerance policy. Additionally, the hospital required Dr. Allen to complete an anger management course at the University of Virginia and to undergo neuropsychiatric testing as part of his suspension evaluation. No specific issues were identified during the evaluation.

6. The Committee reviewed a letter dated January 15, 2013, from H. Lee Kirk, Jr., President and Chief Executive Officer of Culpeper Regional Hospital, reporting that Dr. Allen's privileges were reinstated on July 25, 2012. Mr. Kirk also reported that "Dr. Allen's professional conduct and decorum has improved and there have been no behavioral incidents resulting in action by the CRH medical staff." Further, "Dr. Allen has helpfully engaged with hospital administration and has constructively participated in Hospital initiatives."

7. Dr. Allen acknowledged that the above events occurred over an extended period of time, due to his falling short in communication with his colleagues and staff. His words were not intended to harm, but he understands they were offensive. He is now more aware of what he says and does, and that he is a part of a team. He noted that every member of the team has a role and he is newly dedicated to working with each team member to improve patient care and to ensure he has a positive interaction with others. He puts his patients first and the safety of all members of the team, and tries to approach everyone with positive intent. He stated he was sorry for his previous behavior and embarrassed by it.

ORDER

WHEREFORE, based on the above Findings of Fact and Conclusions of Law, it is hereby ORDERED that Dr. Allen be issued a REPRIMAND.

It is further ORDERED that Dr. Allen shall pay a MONETARY PENALTY in the amount of one thousand five hundred dollars ($1,500.00). Said monetary penalty shall be paid to the Board within thirty (30) days from entry of this Order. Failure to pay the full monetary penalty within the timeframe stipulated may constitute grounds for an administrative proceeding.

Dr. Allen shall maintain a course of conduct in his practice of medicine commensurate with the requirements of Title 54.1, Chapter 29 of the Code and all laws of the Commonwealth.

Pursuant to Sections 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

Pursuant to Section 54.1-2400(10) of the Code, Dr. Allen may, not later than 5:00 p.m., on February 25, 2013, notify William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that he desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated.

Therefore, this Order shall become final on February 25, 2013; unless a request for a formal administrative hearing is received as described above.

FOR THE BOARD

for William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 1/23/2013