BEFORE THE
MISSOURI STATE BOARD OF REGISTRATION FOR
THE HEALING ARTS

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS,	)	
Petitioner,	)	
v.	)	Case Number(s): 2013-003922 and 2014-007312 (AHC Case No. 16-3561)
VADIM Y. BARAM, M.D.,	)	
Respondent.	)	

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCIPLINARY ORDER

The Missouri State Board of Registration for the Healing Arts ("the Board"), in accordance with law and pursuant to proper notice, took up this matter against Vadim Y. Baram, M.D. ("Respondent") during its regularly scheduled meeting on January 15, 2021, via virtually through WebEx, for the purpose of determining the appropriate level of discipline to enter against his physician and surgeon's license.

The Board was represented by Adam Grayson, Contract Counsel for the Board. Katie Brenneke, General Counsel, served as the Board's legal advisor during the hearing; Lucas Boling, Associate General Counsel, served as the Board's legal advisor in preparing this Order. Respondent was present at the hearing, and was represented by counsel, Mr. David Barrett. All members of the Board participating in the decision were present throughout the disciplinary hearing. Dr. David Tannehill, D.O., was not present and did not participate in the decision. In reaching the decision reflected in this Order, each member of the Board present at the hearing read and considered the Administrative Hearing Commission's Decision, Case No. 16-3561, ("AHC's Decision"), entered on September 23, 2020.

At the commencement of the hearing, Petitioner offered Exhibit 1, an affidavit signed by the Board's Deputy Custodian of Records establishing Respondent's physician and surgeon's license number, license status, and business address last reported to the Board; and Exhibit 2, certified records of the Board

containing the notice of disciplinary hearing, return of service, and AHC's Decision. Exhibits 1 and 2 were admitted into evidence. Petitioner, having previously filed a notice of intent to rely on the certified record, requested that the Board consider the certified record from the Administrative Hearing Commission ("AHC"). Respondent did not object to that request. Petitioner moved that the Board seal a portion of the certified record to the extent that it contains patient and other protected information. Respondent concurred and the Board granted Petitioner's motion to seal that portion of the certified record.

Respondent offered Exhibit A, a May 14, 2016 certificate from the International Society of ECT and Neurostimulation certifying that Respondent attended a Certificate Course in Electroconvulsive Therapy and successfully passed the course examination; and Exhibit B, a certificate dated December 12, 2016 for Respondent's participation in the Center for Personalized Education for Physicians Medical Record Keeping Seminar. Petitioner did not object. The Board admitted Exhibits A and B into evidence.

Testimony was adduced and the argument of parties was heard. Being fully advised, the Board now enters its findings of fact, conclusions of law and disciplinary order as set forth below.

Findings of Fact

1. The Board is an agency of the state of Missouri, created and established pursuant to section 334.120, RSMo, for the purpose of executing and enforcing the provisions of Chapter 334, RSMo. [1]
2. Respondent is licensed by the Board as a physician and surgeon, license number 2004022302, which was first issued on August 13, 2004. Respondent's license is current and active, and it was active at the time of the underlying incidents which formed the basis of the AHC's Decision and the current Order.
3. Respondent's business address last reported to the Board is 10420 Old Olive Street Road, Suite 205, St. Louis, Missouri 63141.
4. On September 30, 2016, Petitioner filed a properly pled complaint against Respondent wherein it asked the AHC to find there is cause to discipline his physician and surgeon's license. Respondent filed an answer to the complaint on November 2, 2016. On September 25, 2018, the Board filed a

[1] All statutory references are to the Revised Statutes of Missouri Cumulative Supplement (2018), unless otherwise stated.

motion for leave to amend the complaint and a second motion for leave to file an amended complaint to correct a scrivener's error. On October 1, 2018, Respondent filed an answer to the second amended complaint and affirmative defenses. The AHC granted Petitioner leave to file the amended complaints. On September 25, 2018, Respondent filed a motion for summary decision, suggestions in support of the motion, and a statement of uncontroverted material facts. On October 22, 2018, the Board filed a legal memorandum in opposition to the motion and a statement of uncontroverted facts. By order dated February 28, 2019, the AHC denied Baram's motion. On November 25, 2019, the AHC held a hearing on the complaint. On September 23, 2020, the AHC issued the AHC's Decision determining that Respondent is subject to discipline under sections 334.100.2(4), 334.100.2(4)(c), 334.100.2(4)(l), and 334.100.2(5), RSMo.

5. The Board incorporates by reference and adopts the facts set forth in the AHC's Decision.
6. On November 24, 2000, the Board sent a Notice of Hearing and a copy of the AHC's Decision to Respondent's last known address via certified mail and email to Respondent's counsel.
7. The Board gave Respondent proper notice of this proceeding.
8. Respondent is a practicing psychiatrist who administers electroconvulsive therapy ("ECT") to mentally ill patients as part of his practice in St. Louis, Missouri. ECT treatments involve generating an electrical stimulus to generate a seizure in a patient and are used to treat psychiatric conditions, such as major depressive disorder and bipolar disorder.
9. Respondent treated Patients 1, 2, and 3 in his practice as a psychiatrist and administered ECT to all three patients.
10. During the period of 2009 to 2013, Respondent administered 143 ECT treatments to Patient 1. During the period 2011 to 2013, Respondent administered 97 ECT treatments to Patient 2. During the period of 2010 to 2011, Respondent administered 70 ECT treatments to Patient 3.
11. A physician should decrease or attempt to decrease treatment frequency of maintenance of ECT. The goal is to extend the time between treatments and eventually remove the maintenance treatment. A physician should decrease treatment frequency if cognitive side effects are present.
12. Respondent did not attempt to reduce the frequency of ECT therapy for Patient 1, 2, or 3.

13. Part of the clinical care and maintenance treatment is re-evaluating the patient regularly to determine if maintenance treatment should be continued. The patient's present condition must be analyzed each day, not just over the course of years. Determining whether ECT treatments should continue includes assessing the patient before beginning ECT treatments and after, then again on every visit. The patient assessment should occur within 24 hours after treatment, usually within 10 minutes. The assessment is one that only the physician does and is not something that the physician can have a nurse do on his or her behalf.
14. Respondent did not perform assessments within 24 hours of performing ECT.
15. The psychiatrist is responsible for determining the rationale for and making a medical decision to continue ECT treatments and if continuing is appropriate.
16. The purpose of medical records is to convey information regarding the patient's treatment and health. Medical records allow a doctor or health care provider to later review the records and determine what was happening with the patient. It is important for the information put into the medical chart to be patient specific.
17. The rationale and indications for continuing ECT treatment should be included in the medical records. Respondent failed to include information sufficient to justify continuing ECT treatment for Patients 1, 2, and 3. Respondent provided no documentation of any plan and frequently any attempt to decrease the frequency of treatments.
18. Respondent admitted ECT should not happen without an assessment. Respondent failed to properly note assessments and did not adequately determine if any cognitive side effects were present after each administration of ECT.
19. When documenting his treatment of Patients 1, 2, and 3, Respondent copied and pasted repetitive phrases; failed to include relevant information including side effects, physical examinations, and cognitive assessments; and used nearly identical, non-specific phrases instead of recording new assessments at each patient visit. Respondent recorded the exact same line in Patient 1 's chart 27 times, repeated another line 19 times, and repeated two subsequent lines 13 and 14 times. In Patient 2's chart, Respondent repeated a single line 36 times, repeated another line 26 times, and repeated

a later note 14 times, respectively. In Patient 3's chart, Respondent repeated one line 12 times and another 11 times. Additionally, Respondent placed incorrect patient information into Patient 3's chart seven separate times during visits between July 27, 2010 through August 5, 2010, when he erroneously documented Patient 3 as an "African American male" with a diagnosis of schizophrenia. Patient 3 was a white female with a diagnosis of Bipolar I disorder.

20. There is essentially no documentation by Respondent of Patient 1's cognitive function and no documentation of psychiatric symptomology in her outpatient notes.

21. There is minimal documentation of Patient 2's cognitive function or psychiatric symptoms outside of the notes created during hospitalizations. On May 18, 2012, Respondent changed Patient 2's diagnosis from Schizophrenia to Bipolar I disorder, but provided no documentation of symptoms or rationale for the change in diagnosis. On May 25, 2012, Respondent documented in Patient 2's chart that Patient 2 was "... doing better thusly justifying continuation therapy ..." but provided no further description of Patient 2's status or condition. Respondent made this same notation on 36 subsequent entries without providing any further justification.

22. There is no evidence in the medical records of Patients 1, 2, and 3 that Respondent sufficiently assessed the cognitive side effects and the present condition of the patients.

23. Respondent acknowledged the concerns regarding his recordkeeping and admitted that he made mistakes during the time he was transitioning from paper medical records to electronic medical records (Hearing Tr. 42:25-43:4, 48:21-49:5, January 15, 2021). Respondent completed a recordkeeping course in December 2016 (Hearing Tr. 41:20-23, January 15, 2021; Exhibit B). To avoid recordkeeping errors Respondent now reviews his entry in the patient's electronic chart and then closes that chart before opening another patient's electronic chart (Hearing Tr. 49:6-49:21, January 15, 2021).

24. The Board finds the discipline imposed herein is necessary to protect to the public.

Conclusions of Law

25. Pursuant to section 621.110, RSMo:

> Upon a finding in any cause charged by the complaint for which the license may be suspended or revoked as provided in the statutes and regulations relating to the profession

or vocation of the licensee and within one hundred twenty days of the date the case became ready for decision, the commission shall deliver or transmit by mail to the agency which issued the license the record and a transcript of the proceedings before the commission together with the commission's findings of fact and conclusions of law. The commission may make recommendations as to appropriate disciplinary action but any such recommendations shall not be binding upon the agency. A copy of the findings of fact, conclusions of law and the commission's recommendations, if any, shall be delivered or transmitted by mail to the licensee if the licensee's whereabouts are known, and to any attorney who represented the licensee. Within thirty days after receipt of the record of the proceedings before the commission and the findings of fact, conclusions of law, and recommendations, if any, of the commission, the agency shall set the matter for hearing upon the issue of appropriate disciplinary action and shall notify the licensee of the time and place of the hearing, provided that such hearing may be waived by consent of the agency and licensee where the commission has made recommendations as to appropriate disciplinary action. In case of such waiver by the agency and licensee, the recommendations of the commission shall become the order of the agency. The licensee may appear at said hearing and be represented by counsel. The agency may receive evidence relevant to said issue from the licensee or any other source. After such hearing the agency may order any disciplinary measure it deems appropriate and which is authorized by law. In any case where the commission fails to find any cause charged by the complaint for which the license may be suspended or revoked, the commission shall dismiss the complaint, and so notify all parties.

26. The Board has cause to discipline Respondent pursuant to sections 334.100.2(4), 334.100.2(4)(c), 334.100.2(4)(l) (for violating section 334.097), and 334.100.2(5), RSMo, which state:

334.100.2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by this chapter or any person who has failed to renew or has surrendered the person's certificate of registration or authority, permit or license for any one or any combination of the following causes:

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(4) Misconduct, fraud, misrepresentation, dishonesty, unethical conduct or unprofessional conduct in the performance of the functions or duties of any profession licensed or regulated by this chapter, including, but not limited to, the following:

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(c) Willfully and continually performing inappropriate or unnecessary treatment, diagnostic tests or medical or surgical services;

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(l) Failing to furnish details of a patient's medical records to other treating physicians or hospitals upon proper request; or failing to comply with any other law relating to medical records;

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(5) Any conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public; or incompetency, gross negligence or repeated negligence in the performance of the functions or duties of any profession licensed or regulated by this chapter. For the purposes of this subdivision, "repeated negligence" means the failure, on more than one occasion, to use that degree of skill and learning ordinarily used under the same or similar circumstances by the member of the applicant's or licensee's profession;

27. Additionally, section 334.097, RSMo, in pertinent part, provides that:

334.097.1. Physicians shall maintain an adequate and complete patient record for each patient and may maintain electronic records provided the record-keeping format is capable of being printed for review by the state board of registration for the healing arts. An adequate and complete patient record shall include documentation of the following information:

(1) Identification of the patient, including name, birthdate, address and telephone number;

(2) The date or dates the patient was seen;

(3) The current status of the patient, including the reason for the visit;

(4) Observation of pertinent physical findings;

(5) Assessment and clinical impression of diagnosis;

(6) Plan for care and treatment, or additional consultations or diagnostic testing, if necessary. If treatment includes medication, the physician shall include in the patient record the medication and dosage of any medication prescribed, dispensed or administered;

(7) Any informed consent for office procedures.

2. Patient records remaining under the care, custody and control of the licensee shall be maintained by the licensee of the board, or the licensee's designee, for a minimum of seven years from the date of when the last professional service was provided.

3. Any correction, addition or change in any patient record made more than forty-eight hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time and name of the person making the correction, addition or change shall be included, as well as the reason for the correction, addition or change.

4. A consultative report shall be considered an adequate medical record for a radiologist, pathologist or a consulting physician.

28. Pursuant to section 334.100.4, RSMo, finding that there is cause to discipline, the Board may, singly or in combination, warn, censure, reprimand or place Respondent on probation for up to ten (10) years; it may suspend Respondent's license for up to three (3) years; it may restrict Respondent's

license for an indefinite period of time; it may revoke Respondent's license or permanently withhold issuance of his license; it may require Respondent to submit to the care, counseling or treatment of physicians designated by the Board at the expense of the individual to be examined; and it may require Respondent to attend such continuing educational courses and pass such examinations as the Board may direct.

Decision and Disciplinary Order

29. Upon the foregoing findings of fact and conclusions of law, it is the ORDER of the Missouri State Board of Registration for the Healing Arts that the physician and surgeon's license issued to Respondent, Vadim Y. Baram, M.D., number 2004022302, is hereby **PUBLICLY REPRIMANDED.**
30. If Respondent is licensed in other jurisdictions, he shall forward written notice of this disciplinary action to the licensing authorities of those jurisdictions within thirty (30) days of the effective date of this Order. Respondent shall submit a copy of the written notice to the Board contemporaneously with sending it to the relevant licensing authority. If Respondent is not licensed in other jurisdictions, he shall notify the Board of that fact, in writing, within thirty (30) days of the date of this Order.
31. Respondent shall, within thirty (30) days of the effective date of this Order, forward written notice of this disciplinary action to all employers, hospitals, nursing homes, out-patient centers, clinics and any other facility where Respondent practices or has privileges. Respondent shall, contemporaneously with the giving of such notice, submit a copy of the notice to the Board for verification by the Board or its designated representative. If Respondent does not have an employer, staff privileges or practice at any facility, he shall notify the Board of that fact, in writing, within thirty (30) days of the date of this Order.
32. Respondent shall, within thirty (30) days of the effective date of this Order, forward written notice of this disciplinary action to any allied health care professionals that are supervised by Respondent. Respondent shall, contemporaneously with the giving of such notice, submit a copy of the notice to the Board for verification by the Board or its designated representative. If Respondent does not supervise any allied health professionals, he shall notify the Board of that fact, in writing, within thirty (30) days of the date of this Order.

33. For purposes of this Order and unless otherwise specified herein, all reports, documentation, evaluations, notices or other materials that Respondent is required to submit to the Board shall be forwarded to the State Board of Registration for the Healing Arts, Attention: Enforcement, P.O. Box 4, Jefferson City, Missouri 65102.

34. This document shall be maintained by the Board as an open and public record as provided in Chapters 324, 334 and 610, RSMo, and it will report this action to the National Practitioner Data Bank and the Federation of State Medical Boards.

SO ORDERED, EFFECTIVE THIS 13th DAY OF May, 2021.

Katie R. Brenneke

Katie R. Brenneke, Interim Executive Director
Missouri State Board of Registration for the Healing Arts