

**VIRGINIA:**

**BEFORE THE BOARD OF MEDICINE**

**IN RE: BRADLEY W. NICHOLSON, M.D.**  
**License No.: 0101-030962**

**ORDER**

In accordance with Sections 54.1-2919, 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), an informal conference was held with Bradley W. Nicholson, M.D., on December 18, 2002, in Roanoke, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the Informal Conference Committee ("Committee") were: Sue Ellen B. Rocovich, D.O., Chairwoman; James F. Allen, M.D.; and Reverend LaVert Taylor. Dr. Nicholson appeared personally and was represented by Stephen D. Rosenthal, Esquire. The purpose of the informal conference was to inquire into allegations that Dr. Nicholson may have violated certain laws governing the practice of medicine in the Commonwealth of Virginia, as set forth in a Notice of Informal Conference dated June 28, 2002, and a Supplemental Notice of Informal Conference dated November 15, 2002.

**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. Bradley W. Nicholson holds License Number 0101-030962, originally issued by the Board on July 30, 1979. Said license will expire on February 29, 2004, unless renewed or otherwise restricted.
2. Dr. Nicholson submitted to an evaluation at the Professionals at Risk Program in Elmhurst, Illinois, on August 1-2, 2001, and an evaluation at the Medical College of Virginia Addiction Medicine Department on October 2, 2002. Based on the review of these reports and the statements presented, the Committee determined that there was insufficient evidence to support that Dr. Nicholson is impaired.

3. Dr. Nicholson violated Section 54.1-2915(A)(3), as further defined in Section 54.1-2914(A)(8) of the Code, in that the Committee reviewed several cases and determined that there was a pattern whereby Dr. Nicholson failed to complete operative notes in a timely fashion, which placed patients at risk of harm. Specifically, three patients were transferred to other medical facilities for more extensive care without complete operative notes being available to the subsequent treating physicians.

4. Dr. Nicholson violated Section 54.1-2915(A)(3), as further defined in Section 54.1-2914(A)(8) of the Code, in that Dr. Nicholson indicated that he dictated approximately 5% of his operative notes late, with one being dictated as much as 45 days after the procedure. Documentation from Carilion Giles Memorial Hospital (“Giles Memorial”), Pearisburg, Virginia, indicated that since January 2002 until Dr. Nicholson’s suspension he failed to complete operative notes when due on 91 occasions and failed to complete discharge summaries when due in 34 cases. This delay is inconsistent with good medical practice.

5. Dr. Nicholson violated Section 54.1-2915(A)(3), as further defined in Section 54.1-2914(A)(8) of the Code, in that on two occasions, March 16, 2002 and April 13, 2002, Dr. Nicholson requested the hospital operator to call in the operating room crew, bypassing the nursing supervisor. Documentation reveals that on March 16, 2002, Dr. Nicholson requested the operator not inform the nursing supervisor. Further, Dr. Nicholson engaged in inappropriate behavior as documented on March 16, 2002, when he requested other employees to act in contravention of stated hospital procedures and protocols.

6. Dr. Nicholson violated Section 54.1-2915(A)(3), as further defined in Section 54.1-2914(A)(8) of the Code, in that on or about June 19, 2001, Patient A, a 62 year-old female, was diagnosed with squamous cell carcinoma of the upper left lobe. Dr. Nicholson scheduled a

pneumonectomy at Giles Memorial, instead of referring Patient A to a hospital in the area where a thoracic surgeon was available. On July 17, 2001, Patient A was admitted to Giles Memorial for the scheduled procedure. Prior to surgery, Dr. Nicholson failed to order the typing, screening and crossmatching of Patient A's blood. During surgery, Patient A hemorrhaged from her pulmonary artery, losing approximately 4200cc of blood. Patient A suffered profound bradycardia and hypotension as a result of the acute blood loss. Patient A subsequently went into cardiac arrest, and cardiac massage was performed. Dr. Nicholson failed to record the incidence of cardiac arrest and the subsequent cardiac massage in his operative note.

7. Dr. Nicholson violated Section 54.1-2915(A)(3), as further defined in Section 54.1-2914(A)(8) of the Code, in that on February 22, 2000, Dr. Nicholson inserted a Port-a-cath outside normal operating room hours without the aid of fluoroscopy in Patient C. A subsequent x-ray two hours postoperatively indicated that the Port-a-cath was not properly placed. Dr. Nicholson incorrectly interpreted a contrast injection on February 25, 2000, in determining that the Port-a-cath was within the venous system, when the tip was extravascular. This improper placement was not addressed until March 3, 2000, when it was replaced, thus placing the patient at risk.

### **ORDER**

Based on the above Findings of Fact and Conclusions of Law, it is hereby ORDERED that Bradley W. Nicholson, M.D., be issued a REPRIMAND, subject to the following term and condition.

1. Within six (6) months of entry of this Order, Dr. Nicholson shall successfully complete a course in medical record keeping consisting of at least 14 hours, which shall be approved in advance of registration by the Executive Director of the Board. Any continuing education hours obtained for the requirement of license renewal shall not be used towards compliance with this term.

2. Dr. Nicholson 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.

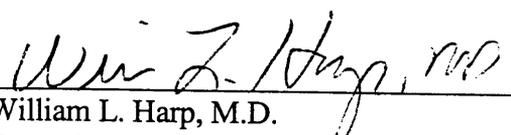
Upon receipt of evidence that Dr. Nicholson has complied with the requirements of this Order, the Executive Director of the Board may close this matter without further proceedings. In the event Dr. Nicholson fails to comply with the requirements of this Order, in the Board's discretion, he may be noticed to meet with an informal conference committee to determine whether further sanctions shall be imposed against his license.

Pursuant to Section 2.2-4023 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 54.1-2919 of the Code, Dr. Nicholson may, not later than 5:00 p.m., on January 27, 2003, notify William L. Harp, M.D., Executive Director, Board of Medicine, 6603 West Broad Street, Richmond, Virginia 23230, 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 January 27, 2003, unless a request for a formal administrative hearing is received as described above.

FOR THE BOARD

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

ENTERED: 12/23/02