STATE OF MAINE
BOARD OF LICENSURE OF PODIATRIC MEDICINE

In re: *Adam W. Darcy*, D.P.M.	)	
	)	DECISION AND ORDER
Adjudicatory Hearing	)	
No. 2024-20436	)	

I. INTRODUCTION

On December 11, 2025 the Maine Board of Licensure of Podiatric Medicine ("the Board") met in person in public session, and also on the online audio/video conference platform Zoom, for an adjudicatory hearing to consider alleged grounds for discipline against the license of Adam W. Darcy, D.P.M. ("the Licensee") to practice podiatric medicine in the state of Maine.[1] An Amended Notice of Hearing dated November 6, 2025 alleged gross negligence, incompetence, and violation of a standard of practice by performing an Achilles tendon and peroneal tendon repair of a patient's right foot when the Licensee should have performed the repair on the left foot, in violation of 10 M.R.S. § 8003(5-A)(A)(2).[2]

A quorum of the Board was in attendance during all stages of the proceeding. Participating members who heard evidence in person were Board Chair Shannon Meredith, D.P.M; and Christopher E. Sacco, D.P.M., Vice-Chair. Board members Brad G. Samojla, D.P.M., and Richard Angotti participated remotely via Zoom. The Licensee was present during all stages of the proceedings and was represented by Mark V. Franco, Esq. John E. Belisle, Assistant Attorney General ("AAG"), assumed the role of the moving party on behalf of the Board's Staff. F. Mark Terison, Esq., a licensed Maine attorney present under the terms of a contract with the Maine Department of Professional and Financial Regulation, presided as independent hearing officer and as counsel to the Board outside of the Office of Attorney General. Under 5 M.R.S. § 9063(1), the hearing officer and each participating member of the Board determined on the record the absence of bias or conflict of interest.

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[1] Virtual or remote public access to the hearing occurred pursuant to the provisions of 1 M.R.S. §403-B and the Board's Board Member Remote Participation Policy, adopted March 9, 2023. Instructions for remote public access were available on the Board's website in advance of the hearing.

[2] An earlier Notice of Hearing had scheduled the adjudicatory hearing for October 2, 2025, but the matter was continued for hearing when the Board could not muster a quorum to conduct business.

Without objection, the hearing officer admitted in evidence the Board Staff 's proposed exhibits 1 through 12, as follows:

1. Notice of Hearing
2. ALMS licensing data for Dr. Darcy
3. Complaint dated 10/9/24
4. Notice of Complaint to Dr. Darcy dated 11/8/24
5. Email from Dr. Darcy to Board Staff dated 9/3/24
6. Response to Complaint from Dr. Darcy received on 12/10/24
7. Treatment records dated 7/6/23-8/2/24 CONFIDENTIAL
8. Documents from St. Joseph Hospital to Board Staff dated 1/8/25-1/9/25 CONFIDENTIAL
9. Emails from St. Joseph Hospital to Board Staff dated 1/8/25-1/9/25 CONFIDENTIAL
10. Letter from Northern Light Health to Dr. Darcy dated 1/13/25
11. Consent Agreement in 2019-POD-15895 effective 4/1/20
12. 10 M.R.S. § 8003(5-A)

The Licensee proposed five hearing exhibits, but they all related to a claim of Board bias that the hearing officer found was sufficiently addressed under 5 M.R.S. § 9063(1). Accordingly, the exhibits were excluded from evidence.[3] In addition, the Licensee proposed a series of eleven questions to be posed to the participating Board members, also addressing alleged bias. The hearing officer refused to pose the questions, but directed that the Licensee's proposed exhibits and questions for members of the Board be preserved in the administrative record for any subsequent review. Also admitted in evidence was Joint Exhibit 1, a written stipulation in which the Licensee admitted the facts alleged in the Amended Notice of Hearing to the extent that they established his negligence and violation of a standard of practice. As a result of the stipulation, the Board Staff dismissed allegations of gross negligence and incompetence.

The Board heard opening statements and the sworn testimony of Brenda Flanagan via Zoom, and the Licensee in person. Following the testimony, the Board

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[3] The Licensee's proposed exhibits consisted of 1). Minutes of the Board of Licensure of Podiatric Medicine, March 6, 2025; 2). Letter from AAG Samantha Andrews to Adam Darcy, PDM, March 10, 2025 with proposed Consent Agreement; 3). Agenda of the Board of Podiatric Medicine, May 1, 2025; 4). Transcript of the May 1, 2025 Board Meeting; and 5). Proposed Consent Agreement submitted to the Board for consideration on May 1, 2025.

Staff and the Licensee presented closing arguments. Thereafter, the Board publicly deliberated, made factual findings, and reached conclusions of law.

II. FINDINGS OF FACT

The preponderance of credible evidence established the following facts:

Joint Exhibit 1. Maine licensed podiatrist Adam W. Darcy, D.P.M., treated a patient for left foot pain monthly in 2023 from July through December. Following the result of an MRI of the patient's left leg, the Licensee recommended surgical repair of the left Achilles and peroneal tendons. On February 28, 2024, the Licensee reviewed with the patient the plan to repair the left Achilles and peroneal tendons. However, surgery was delayed until July 26, 2024 due to the patient's hypertension. On that date at St. Joseph Hospital, the Licensee performed a repair of the right Achilles and peroneal tendons, but prepared an operative report stating the surgery had occurred on the left. In an addendum dated August 2, 2024, the Licensee wrote: "Shortly after the procedure was performed to repair the Achilles and peroneal tendon it was discovered we erroneously performed the repair on the right foot rather than the left" (Joint Exhibit 1).

The Licensee reported the incident to the Board, and St. Joseph Hospital also reported it on September 23, 2024. On October 9, 2024, Board Staff filed a complaint against the Licensee's license, and in his response to the complaint the Licensee admitted he performed a wrong site surgery. He explained that the patient was marked appropriately preoperatively, but upon transfer to the operating room a nurse placed the sequential stocking on the wrong limb, the right leg was erroneously prepped for surgery, and a tourniquet placed erroneously on the right thigh. The hospital revoked the Licensee's surgical privileges on December 23, 2024, and Northern Light Health followed suit on January 13, 2025 (Joint Exhibit 1).

Hearing Testimony. Operating Room nurse Brenda Flanagan recalled seeing the Licensee with a marker in his hand, but did not see him mark the patient. She remembered it being a hectic morning because of a number of things that were challenging. First, there were "issues" concerning the computer which were preventing the Licensee from accessing images of the tendons, and she recalled him saying he would cancel the procedure if he could not access the images. Once the computer was working, Nurse Flanagan next recalled that a medication infusion pump alarm began sounding. The anesthesiologist did not know immediately how to address it, thus requiring yet additional for the procedure that was already "running late." Following

intubation, four or five of those present helped turn the patient to the prone position (Flanagan testimony).

Nurse Flanagan told the Board that she knew "a mark had been done," and when she did not see a mark on the left leg, she placed the sequential stocking on it in error. She recalled that the Licensee was checking x-rays at the time. However, the Licensee was present and assisted her when she placed the thigh high tourniquet on the right leg. A "time out" was taken after placement of the sequential stocking, and Nurse Flanagan recalled reading the patient's consent aloud, and then asking whether there were any questions or concerns. None of the 7 individuals in the operating room responded.[4] She recalled "nothing unusual" about the resulting surgery, and described it as "uneventful." However, when the Licensee came in afterward and said, "We did the wrong leg," she "felt shock and disbelief" (Flanagan testimony).

The Licensee testified there was no question that he marked both the back and front of the patient's left leg, and that two pictures of the patient's marked leg were in his office file. Because of the operating room computer issue of "insufficient memory," the Licensee recalled that he had to resort to the computer in the charge area to view the patient's images. He then returned to the operating room and remembered going through the "time out" checklist and reading through the patient's consent, and then going to scrub. The Licensee said he helped complete the patient draping and then began the surgery without another "time out." He acknowledged that he should have done the "time out" at that point, that he did not catch that the wrong limb had been prepped, and admitted, "That was my error." He theorized that Hibiclens cleanser, used to prepare the patient, could have taken his marks or perhaps contributed to their fading. Still, he acknowledged that "it did not light a fire in me that I did not see the marks" on the site before proceeding. Even during the surgery it did not occur to him that he was operating on the wrong site. He testified, "I saw tendinosis and discoloration . . . and found a 5 centimeter tear in the peroneal tendon." After learning of the error, he concluded that the patient's tear on the right must have been asymptomatic (Darcy testimony).

III. GOVERNING STATUTES

Under 10 M.R.S. § 8008, the "sole purpose" of the Board is "to protect the public health and welfare." According to the statute, "[t]he [B]oard carries out this purpose by

[4] Nurse Flanagan remembered that in addition to herself, those present in the operating room for the "time out" were Dr. Darcy, his practice partner Dr. Kendall, the anesthesiologist and technician, and an operating room technician with an accompanying orientee.

ensuring that the public is served by competent and honest practitioners and by establishing minimum standards of proficiency in the profession regulated by the [B]oard by testing, licensing, regulating and disciplining practitioners of those regulated professions." Pursuant to 10 M.R.S. § 8003(5-A)(A)(2), the Board may impose discipline for a licensee's negligent practice and for a licensee's violation of a standard of practice. The Board is further authorized by 10 M.R.S. § 8003(5-A)(B) to impose any combination of discipline including denial or refusal to issue a license; the issuance of a warning, censure or reprimand; a license suspension of up to 90 days; license revocation; and conditions of probation for violation of each applicable law or Board rule.

IV. CONCLUSION OF LAW AND SANCTION

The Board discussed the two grounds for discipline remaining in the Amended Notice of Hearing following the Board Staff's dismissal of gross negligence and incompetence and, based upon the evidence and facts recounted in the record of hearing but not specifically mentioned in this Decision and Order, and finding by his own admission that the Licensee had been negligent in his practice and violated a standard of practice, by performing an Achilles tendon and peroneal tendon repair on a patient's right foot when he should have performed the repair on the left, in violation of 10 M.R.S. § 8003(5-A)(A)(2), and had previously received discipline from the Board for a wrong site surgery, the Board deliberated and reached the following conclusion:

By motion made and seconded and adopted upon a vote of 4 in favor and 0 opposed, the Board:

1. Issued a REPRIMAND;

2. Imposed a LIFETIME LICENSE RESTRICTION prohibiting the Licensee from ever performing surgery upon patients under general anesthesia, upon patients in a hospital setting or on an ambulatory basis, and upon patients under circumstances of Monitored Anesthetic Care (MAC);

3. Imposed a LIFETIME LICENSE RESTRICTION limiting the Licensee to the performance of in-office procedures upon patients requiring only local anesthesia; and

4. Imposed a TERM OF PROBATION OF THREE (3) YEARS, beginning on the date of this signed Decision and Order, upon the conditions that

the Licensee keep a monthly log of all in-office procedures by the type of procedure, including detailed descriptions of the procedures undertaken, and that the Licensee make the logs available for review by the Board at least twice each year upon the Board's request and for months of the Board's own choosing.

By motion made and seconded and adopted upon a vote of 4 in favor and 0 opposed, the Board authorized its Chair to issue this Decision and Order without further approval of the Board.

So Ordered.

Dated: January 9, 2026

Shannon Meredith, D.P.M., Chair
Board of Licensure of Podiatric Medicine

Appeal Rights

Pursuant to the provisions of 5 M.R.S. §§ 11001-11002 and the general language following 10 M.R.S. § 8003 (5)(G), any party that appeals this Decision and Order must file a Petition for Review in the Maine Superior Court having jurisdiction within 30 days of receipt of this Order. The petition shall specify the person seeking review, the manner in which the person is aggrieved, and the final agency action which the person seeks reviewed. It shall also contain a concise statement as to the nature of the action or inaction to be reviewed, the grounds upon which relief is sought, and a demand for relief. Copies of the Petition for review shall be served by Certified Mail, Return Receipt Requested, upon the Maine Board of Licensure of Podiatric Medicine, all parties to the agency proceedings, and the Maine Attorney General.