IN THE MATTER OF	*	BEFORE THE
NAMITA AKOLKAR, M.D.	*	MARYLAND STATE BOARD
Applicant	*	OF PHYSICIANS
	*	Case No.: 2221-0008A

* * * * * * * * * * * * *

FINAL DECISION AND ORDER

On February 24, 2021, a disciplinary panel of the Maryland State Board of Physicians (the "Board") issued a Notice of Intent to Deny Application for Initial Medical Licensure Under the Maryland Medical Practice Act ("Notice of Intent") to Namita Akolkar, M.D. (the "Applicant"). The Maryland Medical Practice Act (the "Act") is set forth under Md. Code Ann., Health Occ. §§ 14-101—14-702 (2014 Repl. Vol. & 2020 Supp.). Specifically, the Notice of Intent was based upon the following provisions of the Act:

Health Occ. § 14-205.

(b) (3) Subject to the Administrative Procedure Act and the hearing provisions of § 14-405 of this title, a disciplinary panel may deny a license to an applicant . . . for:

(i) Any of the reasons that are grounds for action under § 14-404 of this title[.]

Health Occ. § 14-404.

(a) Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

. . .

(3) Is guilty of:

. . .

(ii) Unprofessional conduct in the practice of medicine;

(4) Is professionally, physically, or mentally incompetent; [and]

. . .

(11) Willfully makes or files a false report or record in the practice of medicine[.]

On August 30, 31, 2021, and September 1, 2021, the Office of Administrative Hearings held an evidentiary hearing on the Notice of Intent. On November 24, 2021, the Administrative Law Judge ("ALJ"), who presided over the evidentiary hearing, issued a proposed decision which concluded that the charges against the Applicant were proven and recommended that the Applicant's application for initial licensure be denied.

The Applicant filed exceptions, and, on February 23, 2022, an exceptions hearing was held before Board Disciplinary Panel B ("Panel B" or the "Panel").

FINDINGS OF FACT

Panel B finds the following facts proven by the preponderance of evidence:

1. On May 14, 2014, the Applicant graduated from Howard University College of Medicine with a doctor of medicine degree.

2. After completing a one-year surgical internship at the University of Connecticut School of Medicine, in July 2015, the Applicant enrolled in a surgical residency program at a university Hospital ("Hospital 1").[1] Hospital 1 is in Washington, D.C.

3. The Hospital 1 surgical residency program is a five-year program with increasing responsibility and independence each successive year. First-year residents are responsible for information gathering and documentation as the first point of contact with patients. Second and third-year residents are expected to participate in consultations to evaluate new patients and discuss these evaluations with senior residents and attending physicians ("attendings"), who are physicians

[1] Where possible, in order to preserve any reasonable expectations of privacy and confidentiality, this decision does not specifically identify hospitals, physicians, or patients.

working with the residents. The attendings have completed their formal education and training.[2] Third, fourth and fifth-year residents supervise junior residents, rotate outside of the hospital to other residency programs, and perform surgeries.

4. Residents are routinely subjected to evaluations and assessments. As part of the evaluation process, a resident is provided with feedback, sometimes in the form of a written evaluations to which the resident is offered an opportunity to respond.

5. Following each rotation, the chief of the department evaluates the resident, giving a rating of 1 to 5. If a resident receives a global rating below 3, the resident is considered to have failed the rotation.

6. The Applicant completed her first postgraduate year (PGY-1) in good academic standing, meeting all benchmarks.

7. On June 28, 2016, however, an attending wrote an Early Warning Note to the Program Director of the Applicant's residency program, citing the Applicant for a "critical incident" and a "series of 'red' flags" which described the Applicant's problem behavior as: "Lying about details related to patient care to the chief & attending. Decisions were being made about patient care based on information being provided which was not correct."

8. The Applicant completed her second postgraduate year (PGY-2) in good standing, meeting all benchmarks.

9. The Applicant was promoted to her third postgraduate year (PGY-3) but started to struggle, both academically and in her performance.

[2] Dr. 1 testified that he was the senior attending in the Applicant's residency program. When asked what it means to be the senior attending, Dr. 1 testified, "It means I'm a professor of surgery with full tenure rank, which is the highest faculty rank in the university for teaching."

10. Following its review of the evaluations or based on any concerns raised during the residency period, the Clinical Competency Committee ("CCC") may meet with a resident to discuss complaints, concerns, and ways to support and improve the resident's performance. The CCC documents the meetings and maintains records of these interactions in the resident's files. Notes and Minutes of the CCC meetings reflect the concerns raised at the meeting and the statements of committee members, the Applicant, and other participants. The CCC met to address the Applicant's conduct three times.

11. In September 2017, during the Applicant's rotation in the transplant division at Hospital 2, a postoperative patient of the Applicant was decompensating. Instead of the Applicant, a nurse from another unit ensured that a chest x-ray and arterial blood gas ("ABG") were ordered. Due to concerns about the Applicant, the staff called a fellow from another unit, the surgical intensive care unit ("SICU"). The Applicant was dismissive and rude to both the nursing staff and the transplant fellow, which the nurses felt interfered with patient care. The patient was transferred to SICU with shock liver and cardiac ischemia.

12. On January 11, 2018, the CCC held a meeting to address the Applicant's professionalism related to her interactions with nursing staff while on the transplant rotation at Hospital 2. The CCC also discussed the Applicant's rotation at Hospital 3. At Hospital 3, the Applicant was "not prepared for surgery," demonstrated "inadequate perioperative management," and "poor postoperative follow up with respect to laboratory order."

13. On March 2, 2018, while on rotation at Hospital 4, the Applicant was asked to consult on a diabetic patient's foot wound. The Applicant did not check the patient's laboratory test results, failed to perform a thorough evaluation of the patient, and missed indicators of a more serious infection during her evaluation. The Applicant misdiagnosed the wound as a foot ulcer

with poor arterial inflow" and recommended a consult with the vascular attending surgeon at a later time. The wound actually was a "necrotizing infection with tissue gangrene," necrotizing fasciitis, which required an emergency below the knee amputation the following day.

14. At the April 2, 2018, CCC meeting, the Committee discussed concerns regarding the March 2, 2018, foot wound incident. The Committee also discussed the Applicant's failure to communicate pertinent patient information at sign-out, including high fevers and hypotension over the night, her failure to follow-up on laboratory results, and her inaccurate report of patient laboratory results and vitals to senior residents and attendings, including her reports that the patient was "fine" when laboratory results indicated otherwise.

15. Also in April 2018, the Applicant was placed on automatic remediation for not meeting the benchmark on the American Board of Surgery In-Training Examination ("ABSITE"). At that time, her ABSITE score was in the seventh percentile, meaning that she only scored higher than 7% of other residents at her same level of training.

16. In May 2018, Hospital 1's CCC and Surgical Education Committee ("SEC") completed an interval review of the Applicant's competency evaluation and performance in the ambulatory and inpatient setting and operating rooms pursuant to the Accreditation Council for Graduate Medical Education ("ACGME") guidelines.

17. The CCC and SEC determined that the Applicant failed to meet expectations in surgical competencies and milestones required under the ACGME guidelines based on the following deficiencies:

- Failure to demonstrate the medical knowledge, patient care skill expected based on the current stage of training;
- Poor demonstration of clinical judgment in the independent management of patients in the clinical setting;
- Poor decision making in the independent management of patients in the clinical setting;

- Inability to clearly, articulately, and effectively exchange information and communicate patient information;
- Inability to efficiently coordinate patient care within the health care system relevant to clinical specialty;
- Poor incorporation of formative evaluation feedback into daily practice; and
- Failure to adhere to ethical principles by providing misleading information regarding patient care in the clinical setting.

18. The CCC developed a remediation plan for the Applicant which required her to repeat her PGY-3 with the following supports and requirements:

- You will return at a level equivalent to that of a PGY III on probation effective July 1, 2018. We have designated a special remedial program (July 1, 2018, to June 30, 2019) that provides both oversight and opportunity for expanding your clinical, professional and academic acumen.
- You will be expected to demonstrate the academic competencies required of all [Hospital 1's] surgical residents in good standing.
- You will be expected to meet with your academic mentor, Dr. [ ] within two weeks. Your designated faculty mentor Dr. [ ], and you are expected to meet on a monthly basis.
- You will also be expected to meet with your professionalism mentor, Dr. [ ], within 1 month. You are expected to meet at least every two months.
- SCORE, TrueLearn, Sesap, Pass Machine and Access Surgery are available for online academic support. All access codes are available through the Surgery Residency Office.
- You will be expected to provide a study plan that is approved by your academic mentor, Program Director and Clinical Competency Committee Chair by June 4, 2018.

Under this plan, the CCC and Program Director conducted routine assessments of the Applicant and the Applicant was provided additional support through a professionalism mentor. Throughout this period, the Applicant maintained contact with her mentors and the Program Director.

19. During the Applicant's repeat PGY-3, she met the requirements of the remediation plan and all benchmarks. She was promoted to her fourth postgraduate year (PGY-4).

20. During the beginning of her PGY-4, the Applicant started to exhibit similar problems as those requiring remediation during her first PGY-3.

21. On August 15, 2019, while on surgical rotation at Hospital 5, the Applicant failed to confirm her patient's Endoscopic Retrograde Cholangiopancreatography ("ERCP") result.[3] When asked by the attending surgeon for the ERCP result prior to the surgery, even though she did not review the ERCP results, the Applicant incorrectly informed the attending that a gallstone had passed and was no longer present. After the patient was anesthetized, the attending sought to confirm the Applicant's report regarding the ERCP. After contacting the gastroenterology unit that performed the ERCP, the attending found out that a 4 cm stone was still present and had not passed, thus, the patient needed a different surgery than the one scheduled. Because the patient required a different procedure, the surgery that was scheduled was cancelled, the patient was awakened from anesthesia and reconsented for the correct procedure, which was later performed.

22. The Applicant was also involved in an incident in which she was operating on a patient with a difficult gallbladder issue. The attending had concerns about her performance. The attending told her to stop operating and asked for another resident to complete the surgery. Despite the attending asking her to stay so she could learn how to correctly perform the surgery, the Applicant left the operating room.

23. At the conclusion of her rotation at Hospital 5, the Applicant received a below expectation clinical evaluation score and a global rating of 2, which meant that she failed the rotation.

24. The CCC investigated the reasons for the Applicant's rating and failure. It interviewed attending surgeons and residents who worked with the Applicant on the rotation at Hospital 5.

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[3] The ERCP report contained information regarding an obstruction in the patient's bile ducts. The type of surgery was dependent on knowing if the stone was present and its location.

25. The Hospital 5 attendings listed specific areas of concern regarding the Applicant's performance, including "report[ing] things in the morning about patients without seeing them," arriving late "on a regular basis," lying, being condescending to junior residents and physician assistants, and demonstrating "a serious lack of medical knowledge." They reported cases in which the Applicant misdiagnosed patients and questioned whether the Applicant could correctly determine whether a patient "was sick or not sick." Several of the attendings and all of the residents reported that the attendings believed it was necessary to doublecheck any information provided by the Applicant because they did not trust her.

26. In Hospital 1's investigation of the Applicant, Hospital 1 learned of a situation in which the Applicant failed to properly diagnose a patient with appendicitis. The patient came to the hospital with lower right quadrant abdominal pain. The CT scan was suggestive of acute appendicitis. Without seeing the patient, the Applicant looked at a laboratory result showing white blood cells in the urinalysis and decided the patient had a urinary tract infection. The physician assistant and all of the other residents involved in the case determined that the patient had acute appendicitis. At rounds, the Applicant took the entire team into the patient's room, and when the Applicant palpated the patient's lower right quadrant the patient "literally jump[ed] out of bed in pain." Nonetheless, at the morning report, the Applicant told the attending that the patient had a urinary tract infection. After the morning report, the rest of the team explained the situation to an attending and took the attending to the patient. In the end, the patient required an appendectomy.

27. In another instance, the Applicant could not put in a chest tube properly. The chest tube was not draining. The attending asked her to redo the installation of the chest tube. The Applicant then expressed her frustration with the attending. The new chest tube was still insufficient, and the attending asked her to pull it out more and re-stitch. The Applicant asked why

it had to be re-stitched, and the attending responded, "'[Y]ou are going to be a 4th year in less than a month and I shouldn't even have to be here for this!'"

28. The CCC met with the Applicant on November 11, 2019, to discuss the Applicant's below expectations rating and failure of the rotation.

29. At the meeting, the Applicant attributed the below expectations rating to the following:

> [I] had a rough time with the particular attending who wrote the evaluation on a personal level. 'When I was a third year when I asked her for feedback she told me that she didn't like me and thought I [was] arrogant. Any mistake I made after that just cemented her opinion of me. When I returned as a fourth year, I made the mistake of not doing anything to change her opinion of me.'

30. In December 2019, the Applicant supervised a junior resident who performed a wound closure. The wound was not safely closed with "significant gaps in the wound suturing."

31. On December 2, 2019, Dr. 1 sent an email to the Program Director raising concerns regarding the Applicant's continued "deficient" performance which he reported to be "below her PGY level."

32. At the conclusion of the CCC investigation, it determined that the circumstances which were discussed at the November 2019 CCC meeting and subsequent observations supported the Applicant's termination from Hospital 1's surgical residency program based on the following deficiencies:

- Failure to demonstrate the medical knowledge, patient care skill expected based on the current stage of training;
- Poor demonstration of clinical judgment in the independent management of patients in the clinical setting;
- Poor demonstration of professionalism in the clinical setting;
- Inability to clearly, accurately, and effectively exchange information and communicate patient information;
- Inability to effectively coordinate patient care within the health care system relevant to clinical specialty;

- Poor incorporation of formative evaluation feedback into daily practice;
- Failure to satisfactorily complete the two-month rotation at [Hospital 5] as a PGY IV general surgery resident; and
- Failure to adhere to ethical principles by providing misleading information regarding patient care in the clinical setting.

33. On February 24, 2020, Hospital 1 informed the Applicant that she was terminated from Hospital 1 and Hospital 1's Surgical Residency Program based on her "failure to meet the core competencies and milestones required by the Residency program and the Accreditation Council for Graduate Medical Education ("ACGME")."

34. The Applicant requested that Hospital 1 reconsider its decision to terminate her from the program.[4]

35. On March 27, 2020, the SEC conducted a hearing to review the decision to terminate the Applicant from Hospital 1's residency program. Both the residency Program Director and the Applicant presented statements and responded to questions posed by the SEC.

36. The Program Manager reviewed the Applicant's history in the program and recommended that she be terminated from the program "and not allowed to move ahead." The Applicant presented evidence against termination, including her ABSITE scores, evaluations, and letters of support.[5] She requested that the SEC consider resolving the matter according to a proposed settlement agreement which, among other terms, would allow her to resign from the surgical residency program and continue in another residency program.

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[4] Hospital 1's grievance process permits a resident "the right to ask for reconsideration of academic or other disciplinary actions taken against [the resident] that could result in dismissal, non-renewal of a resident's agreement or other actions that could significantly threaten a resident's intended career development."

[5] The Applicant's ABSITE scores significantly improved between 2018 and 2020; her 2019 ABSITE score was in the thirteenth percentile and her 2020 ABSITE score was in the eighty-first percentile.

37. The SEC voted unanimously to uphold the Applicant's termination from the residency program and informed the Applicant of this decision in a letter dated April 7, 2020, and/or April 8, 2020.[6]

38. The Applicant has never been licensed to practice medicine in Maryland.

39. On June 1, 2020, the Applicant signed an Application for Initial Medical Licensure ("Application") with the Board, in which the Applicant sought a license to practice medicine in Maryland. The Board received the Application on June 5, 2020. On the Application, the Applicant answered "YES" to the following questions:

> 13c. During your years of postgraduate training, was any action taken against you by any training program, hospital, medical board, licensing authority, or court? Such actions include but are not limited to investigations, limitations of privileges or special conditions, requirements imposed for academic incompetence, disciplinary actions, probationary action, etc.
>
> 16f. Has a hospital, related health care facility, HMO, or alternative health care system ever denied your application; failed to renew your privileges, including your privileges as a resident; or limited, restricted, suspended, or revoked your privileges in any way?

The Applicant explained her "YES" responses as follows:

> I was terminated from my Surgical Residency at [Hospital 1] in the middle of my fourth year for failure to meet Surgical Academic Milestones.

The Applicant also attached a copy of the February 24, 2020, termination letter from Hospital 1.

40. On July 2, 2020, the District of Columbia issued a medical license to the Applicant.

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[6] Hospital 1's residency file of the Applicant contains two letters—one dated April 7, 2020, and the other April 8, 2020—notifying the Applicant that the SEC upheld the decision to terminate her from the General Surgery Residency Program. The April 7, 2020, letter says that the minutes of the SEC meeting are enclosed, while the April 8, 2020, letter does not mention the meeting minutes.

41. On August 12, 2020, the Board sent an email to the Applicant noting that she "did not include an expanded written explanation" regarding her termination from the residency program. It offered her the opportunity to submit a more detailed explanation before her file was reviewed by the Board.

42. On August 14, 2020, the Applicant responded to the Board's August 12, 2020, email and attached a letter in which she stated:

> Surgical residency at [Hospital 1] was just not the right fit for me. I made a few errors along the way and was dismissed for failure to meet surgical academic milestones in my 4th year of training. During my time at [Hospital 1], I learned a tremendous amount and helped several patients along the way. I successfully completed PGY-1-3. I have sought and utilized mentorship to improve. After my departure, my program director [ ] has continued to serve as a mentor of mine and I have continued to receive support and mentorship from my chair and many other attendings in the department. I have devoted 10 years of my life to medicine and have always desired to do what is best for my patients.

43. From February 2021, through May 2021, the Applicant worked as a physician at a COVID-19 testing center in Washington, D.C. She was responsible for evaluating patients and making recommendations on testing and quarantine protocols.

44. In June 2021, the Applicant enrolled in a residency program in public health at another institution.

EXCEPTIONS

The Applicant's exceptions focus on two arguments. First, the Applicant argues that the ALJ improperly relied upon the Applicant's residency file (State's Ex. 2), which the Applicant contends contains unreliable hearsay. Second, the Applicant argues that the ALJ improperly discounted the testimony of the witnesses who testified on her behalf.

The Applicant took exception to the ALJ's Findings of Fact 6, 9-18, 20-34, arguing that each of these findings of fact "was improperly derived from [State's] Ex. 2 [the residency file]."

The Respondent's exceptions, however, do not identify any evidence in the record that contradicts the ALJ's findings of fact at issue.

I. ADMISSIBILITY OF RESIDENCY FILE

The Respondent argues that the ALJ should not have admitted the residency file that Hospital 1 maintained on the Respondent, contending that the residency file contains inadmissible hearsay.

In administrative hearings, hearsay may be admitted into evidence under certain circumstances. Section 10-213 of the State Government Article provides, in pertinent part:

> (b) *Probative evidence.* — The presiding officer may admit probative evidence that reasonable and prudent individuals commonly accept in the conduct of their affairs and give probative effect to that evidence.
>
> (c) *Hearsay.*— Evidence may not be excluded solely on the basis that it is hearsay.
>
> (d) *Exclusions.* — The presiding officer may exclude evidence that is:
>
> (1) incompetent;
> (2) irrelevant;
> (3) immaterial; or
> (4) unduly repetitious.

"Hearsay evidence is admissible before an administrative forum in contested cases and, if such evidence is credible and sufficiently probative, it may be the sole basis for the decision of the administrative body." *Rosov v. Md. State Bd. of Dental Examiners,* 163 Md. App. 98, 113 (2005) (internal quotation marks omitted). Consequently, the fact that the offered evidence is hearsay is not determinative of whether it is admissible. *Travers v. Baltimore Police Department,* 115 Md. App. 395, 413 (1997). In administrative hearings, the critical element to be determined is whether the hearsay evidence is competent. *Para v. 1691 Limited Partnership,* 211 Md. App. 335, 381 (2013). There are three principal factors considered in the competency analysis of the offered

hearsay evidence: reliability, probative value, and fairness. *Travers,* 115 Md. App. at 413. An agency first considers the hearsay evidence's reliability and probative value. *Id.* "Once the offered hearsay is deemed sufficiently reliable and probative, one must then consider whether the hearsay's admission contravenes due process." *Para,* 211 Md. App. at 381-82.

Reliability

Statements made under oath or made close to the time of the incident or corroborated are considered to have an enhanced degree of reliability. *Travers,* 115 Md. App. at 413. The Applicant points out that the statements in the residency file were not made under oath and that the only witness who testified on behalf of the State was a Board licensure analyst. The Applicant further argues that the Licensure Analyst was not able to independently verify who made the statements in the residency file, when the statements in the file were made, nor whether the documents in the file were accurate. The material in the residency file, however, was corroborated through the testimony of the Board's Licensure Analyst; the application for initial licensure filed with the Board; and the Verification of Postgraduate Medical Education form, issued by Hospital 1 and signed by Hospital 1's residency Program Director.

The Board's Licensure Analyst testified as to how she obtained the residency file from Hospital 1. The Licensure Analyst said she reviewed the Applicant's Application to the Board for a medical licensure. The Licensure Analyst saw that the Applicant answered "YES" to question 16.f., which asked whether a hospital had denied her privileges, including her privileges as a resident. A "YES" response requires a detailed explanation from the Applicant. The Applicant's explanation for her "YES" response states,

> I was terminated from my Surgical Residency at [Hospital 1] in the middle of my fourth year for failure to meet Surgical Academic Milestones.

Along with the written explanation, the Applicant attached a letter from the Executive Director of Hospital 1's Human Resource Operations, dated February 24, 2020, addressed to the Applicant, which notified the Applicant that she was terminated from Hospital 1's Surgery Residency Program for her failure to meet core competencies and milestones. The Applicant also submitted a signed release form which authorized the Board to obtain any information from the hospitals and postgraduate programs at which she trained. The Licensure Analyst then asked the Applicant to submit a more complete explanation concerning the denial of her privileges from Hospital 1. The Applicant stated, in relevant part, that Hospital 1 was:

> not a good fit for me, I made a few errors along the way and was dismissed for failure to meet surgical academic milestones in my 4th year of training. . . . After my departure, my program director has continued to serve as a mentor of mine.

The Licensure Analyst also obtained from Hospital 1 a Verification of Postgraduate Medical Education form, which was signed by the Program Director. This form states that the Applicant was "placed on probation within the residency," "terminated February 2020," and "evaluated by the Clinical Competency Committee and placed on institutional review. Resident subsequently terminated for global deficiencies."

The Licensure Analyst then asked Hospital 1 for its complete file on the Applicant and attached the Applicant's release form to the request. In response, Hospital 1 provided the Licensure Analyst with the Applicant's residency file. The Program Director was copied on the cover email to the Board. The email states, "Please find attached, Dr. Akolkar's file for your review & process." The email was sent by the Residency Program Coordinator on behalf of the Program Director.

The material that the Licensure Analyst obtained prior to receipt of the residency file corroborates the information contained in the residency file. For instance, the residency file

contains a copy of the same termination letter from Hospital 1, dated February 24, 2020, that the Applicant attached to her Application to the Board in her response to question 16.f. The residency file also contains a transcription of Hospital 1's hearing, on March 27, 2020, concerning the Applicant's grievance contesting her termination from the Surgery Residency Program. There were two presenters at the SEC hearing: the Applicant and the Program Director. The Chair's opening remarks included the following: "So, Dr. Akolkar was terminated on February 24th, 2020 and this decision to terminate her was based on the recommendation of the Clinical Competency Committee to the program director, [name of Program Director], and it was because of her failures to meet the core competencies and Milestones required by the Residency Program." The residency file also has a copy of the letter from the Chair of Hospital 1's SEC, dated April 8, 2020, which notified the Applicant that the termination from the General Surgery Residency Program was upheld.

The residency file also contains a letter, dated May 9, 2018, and signed May 16, 2018, by Hospital 1's residency Program Director, addressed to the Applicant in which the Program Director notifies the Applicant that the Applicant had to repeat her third year of residency and further provides, "You will return at a level equivalent to that of a PGY III on probation effective July 1, 2018. We have designed a special remedial program (July 1, 2018 to June 30th, 2019) that provides both oversight and opportunity for expanding your clinical, professional and academic acumen." (State Ex. 2 at 88.) Thus, the reliability of the residency file was corroborated by sufficient evidence that was admitted before the ALJ admitted the residency file (Exhibit 2) into evidence.

Further, a residency file contains statements from physicians and health care professionals who are licensed (or who will soon be licensed). Dishonesty in their statements is a basis for

discipline against their license or against licensure. *E.g.*, Health Occ. 14-404(a)(2), (3)(ii), (11). Honesty in the medical profession is of paramount importance, thus statements by medical professionals, concerning their observations of a resident, to those overseeing and involved in a residency program have heightened reliability. *See Cornfeld v. State Board of Physicians*, 174 Md. App. 456, 479 (2007) ("this Court recognized long ago, fundamental principles of medical ethics require that '(a) physician shall deal honestly with patients and colleagues.'"). The Panel finds that the information contained in the residency file is sufficiently reliable.

Probative value

The residency file has more than ample probative value. The residency file contains essential details of the Applicant's deficiencies in her medical skills and judgment. The residency file shows that the Applicant's problems during her residency were long-lasting and profound. As early as June 2016, a named attending physician wrote an Early Warning Note concerning the Applicant, which stated, "Lying about details related to patient care to the chief [ ] attending. Decisions were being made about this patient based on information being provided which was not correct." (State's Ex. 2 at 116.) This type of behavior was a recurring problem and a focus of Hospital 1's oversight committees. For example, in 2019, the Applicant told the attending that a stone had passed through a bile duct, which was inaccurate. The Applicant had not read the endoscopic retrograde cholangiopancreatography ("ERCP") report, and as a result the patient was scheduled for an incorrect surgery, placed under anesthesia, and had to be woken in order for the correct surgery to be scheduled. The Program Director described the Applicant's conduct: "She lied about what happened to the patient. That's the common bile duct patient. The difficult thing for me is that not only did she lie, she had two days to come clean and she never came clean. She allowed the patient to go to the operating room. She allowed that patient to undergo anesthesia,

and she allowed that the attending to reach out to another attending when she knew the information she gave was incorrect." There is no question that the residency file is probative of the issues in this matter.

Fairness

The Court of Appeals has held that an administrative agency must observe basic rules of fairness towards the parties appearing before it. *Fairchild Hiller Corp. v. Supervisor of Assessments,* 267 Md. 519, 523 (1973). "[A] basic tenet of fairness in administrative adjudications is the requirement of an opportunity for reasonable cross-examination." *Travers,* 115 Md. App. at 416-17. But the "principle that hearsay evidence is admissible in administrative proceedings would be vitiated if a party could object to its admission on the ground that he was denied his right to cross-examination. The right to cross-examination, although important and useful, is not absolute." *Beauchamp v. De Abadia,* 779 F.2d 773, 775-76 (1st Cir. 1985). Parties in administrative proceedings are thus not afforded an absolute right to cross-examination, only "an opportunity for reasonable cross-examination." *Travers,* 115 Md. App. at 417.

It has been repeatedly held in Maryland that, in administrative proceedings, if there are procedures giving parties subpoena power, a party waives his or her right to complain about the denial of the opportunity to cross-examine if the party fails to subpoena the witness. *See Para,* 211 Md. App. at 386 ("appellants were not deprived of the opportunity to cross-examine witnesses by MDE, by 1691, by the ALJ, or by the FDM; but by their own failure to subpoena witnesses or further documentation."); *Rosov,* 163 Md. App. at 117 ("Rosov was not deprived of the opportunity to cross-examine Bartem by the State or the ALJ, but by his own failure to subpoena the witness."); *Travers,* 115 Md. App. at 418 ("because appellant failed to exercise his right to

subpoena Ms. Nelson, . . . , we conclude that he has effectively waived his right to complain about a denial of the opportunity to cross-examine Ms. Nelson.").

OAH has extensive procedures furnishing parties with the power to subpoena witnesses. Upon request of a party, OAH may issue subpoenas requiring the attendance and testimony of witnesses. COMAR 28.02.01.14A. Likewise, an ALJ may authorize the issuance of a subpoena pursuant to § 9-1605(c)(1) of the State Government Article. The Applicant has not complained on exceptions that she has been unable to subpoena a person she would have liked to have testified.[7]

The Applicant testified on her own behalf and presented four witnesses who each testified before the ALJ. One of the witnesses presented by the Applicant, Dr. 1, is referenced numerous times throughout the Applicant's residency file. Dr. 1 is the chief of trauma, critical care, and surgical nutrition at Hospital 1. He testified that the Applicant "rotated on my service many times, and that I had probably extensive exposure to Dr. Akolkar from an educational standpoint." The Applicant's residency file contains an email from Dr. 1 to the Program Director in which Dr. 1 wrote, "[t]he performance of N.A. [Namita Akolkar] continues to be deficient and below her PGY level." (State's Ex. 2 at 127.) Dr. 1 then listed in the email several examples of the Applicant's deficiencies. *Id.* On cross examination, Dr. 1 was shown the email and responded, "This is

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[7] During oral argument on exceptions, the Applicant mentioned that the ALJ did not allow remote testimony for some of her former colleagues, who were out-of-state. The ALJ did allow for these witnesses to submit affidavits. The following individuals submitted affidavits, which were admitted into evidence: EP, M.D. (Ex. 17); MC, D.D.S. (Ex. 18); and MP, D.S.S. (Ex. 19). Each of these affiants had worked with the Applicant during the Applicant's residency and did not observe the Applicant making misrepresentations nor exhibiting rude or dismissive behavior nor interfering in patient care nor engaging in any unprofessional behavior. None of the affiants indicated, however, that they were a witness to any of the specific incidents at issue in this matter. Also, based upon the proffers, the ALJ found the witnesses were essentially character witnesses and that affidavits would be sufficient for their purposes. Because their affidavits did not shed light on the particular incidents at issue, the Panel finds their affidavits of limited value. The ALJ allowed Dr. B to testify by telephone. The Panel finds no error by the ALJ.

definitely my e-mail to [the Program Director] on December the 2nd, 2019. The time was 5:27:39 a.m. And it was regarding Namita Akolkar." (T. 324.) Dr. 1 also testified that he is a member of Hospital 1's CCC and voted to terminate the Applicant from Hospital 1's residency program. At no time during direct or cross examination did Dr. 1 indicate that the residency file was unreliable in any fashion.

The residency file even contains a transcript of the March 27, 2020, grievance hearing, before the Hospital 1 Surgery Education Committee, which was held to give the Applicant an opportunity to contest Hospital 1's decision to terminate her residency. The transcript shows that details of her residency were thoroughly discussed. Further, the transcription contained numerous statements made by the Applicant at the hearing, and the Applicant does not dispute the reliability of the transcription. Moreover, in her exceptions, the Applicant does not identify any specific documents in the residency file that she claims is unreliable, inauthentic, or inaccurate.

The Applicant's exceptions seem to suggest that a number of the documents in the residency file contain statements from anonymous attending physicians, which made it difficult for her to refute those statements. The Applicant, however, does not identify any of the specific statements by an anonymous source to explain how any of these statements affects the factual findings of the ALJ, or if the ALJ relied upon any of these statements. The Applicant, instead, simply repeats the blanket general assertion for numerous findings of fact that the factual finding "was not supported by any witness testimony, and was improperly derived from Board Ex. 2."[8] The Applicant does not attempt to show that any of the ALJ's findings are inaccurate, nor does the Applicant point to any evidence contradicting the ALJ's findings.

[8] The Applicant uses this language for the ALJ's findings of fact 6, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 31, 32, 33, and 34.

In fact, the Applicant's testimony repeatedly confirms the information contained in her residency file. The Applicant acknowledged in her testimony that she "made the error with the misdiagnosis of the patient with necrotizing fasciitis. I failed to correctly identify that patient as having necrotizing fasciitis and he had a delay in having his below the knee amputation." (T. 181.) In terms of not reading the ERCP report, the Applicant testified, ". . . I passed on information that was inaccurate." (*Id.*) The Applicant further confirmed the information in the residency file when she testified, "I have made mistakes post call where I have gotten patients confused and mixed up their numbers because I thought we were talking about the last patient and we had moved onto the next patient." (T. 182.) Furthermore, in numerous instances, the residency file does identify the attendings who were connected to the incidents at issue. The Applicant showed she was very aware of the incidents at issue and did not indicate that she did not know the individuals involved. In any case, the Applicant did not identify which statements or incidents referenced in the residency file of which she was unable to determine the source.

Panel B thus finds that the residency file is reliable, highly probative of the issues in this matter, and that the Applicant was afforded appropriate due process. In sum, the ALJ did not err in admitting the residency file (State's Exhibit 2) into evidence. Panel B denies the Applicant's exception challenging the admission of her residency file into evidence.

II. ASSESSMENTS OF WITNESS TESTIMONY

In addition to her own testimony, the Applicant presented four live witnesses, who testified on her behalf: Dr. 1, Chief of Hospital 1's Trauma Department; Dr. 2, the interim Chair of Hospital 1's Surgery Department; Dr. 3, a clinical assistant professor at Hospital 1; Dr. 4, Hospital 1 Professor and former Chair of the Surgical Department. The intention of their testimony appears to be that they did not personally observe deficient medical practices or unprofessional behavior

by the Applicant. The ALJ noted that she found these witnesses to be "credible and persuasive" in that they testified to "the best of his or her ability, regarding his or her recollection of observations made during the residency." But the ALJ found that the usefulness of their testimony was limited. The ALJ explained that there were instances in which the witnesses "were not aware of specific information or could not recall details regarding certain events." The ALJ also explained that "to the extent that a witness's recollection or testimony is inconsistent with the information contained in the Applicant's residency file, I have relied on the information in the Applicant's residency file which was recorded close in time to when the actual events occurred." As an example, the ALJ recounted Dr. 1's testimony in which he stated that he did not observe any specific instances of unprofessional behavior during the Applicant's residency, but, on cross examination, he was shown an email from December 2, 2019, to the Program Director that he wrote in which he recounted a litany of unprofessional behavior on the part of the Applicant. The ALJ summarized Dr. 1's email:

> the Applicant 'continues to be deficient and below her PGY level.' ([State's] Ex. 2 at 115). In the email, he provided examples of deficient performance by the Applicant such as sending an incorrect operative report to him for his signature which described a different patient and an incorrect procedure; poor supervision of a junior resident for a wound closure, which was performed inappropriately with large gaps in the suturing; discharging patients without appropriate evaluation or documentation; and chronic lateness for rounds 'even after discussing (the Applicant's) being on time issues(.)" ([State's] Ex. 2 at 115).

ALJ's Proposed Decision at 16-17. Interestingly, Dr. 1 wrote this email to the Program Director after he had voted to recommend the termination of the Applicant from the residency program.

The Applicant asserted in her exceptions that "none of the witnesses, except for the Applicant herself, were individuals who were attributed as having made statements contained in the residency file." This is belied by Dr. 1's email. It is also belied by the meeting minutes of the

November 11, 2019, CCC. (State's Ex. 2 at 57-61.) The meeting minutes detail statements made at the meeting by three of her witnesses—Dr. 1, Dr. 2, and Dr. 3—who each then voted at the meeting to recommend the termination of the Applicant from the residency program. (State's Ex. 2 at 61.) Dr. 3 verified on cross examination statements Dr. 3 made at the 2019 CCC that were documented in the meeting minutes in the residency file. Dr. 4 was not part of the CCC.

The ALJ also found significant Dr. 4's testimony that, in the previous 13 years, only 4 out of 107 surgical residents were terminated from the program. The Panel also credits this testimony.

The Applicant took exception to the ALJ's assessment of the witnesses she presented. The Applicant contends that the ALJ erroneously gave little weight to the testimony of these witnesses who all "support the Applicant's ability to practice medicine and application for medical licensure." (Exceptions at page 9.) The Applicant, however, does not address the ALJ's reasoning for finding limited value in their testimony. For example, the ALJ wrote in depth about Dr. 1's December 2, 2019, email in which he lists several examples of the Applicant's unprofessional behavior and clinical deficits. The Applicant simply ignores this. The Applicant's failure to address the ALJ's reasons for not giving limited weight to the testimony of the Applicant's witnesses provides the Panel with little basis to reject the ALJ's valuation of their testimony. Further, the Applicant has not identified specific testimony from these witnesses that would affect any specific finding of fact made by the ALJ nor that would override the information contained in the residency file. In fact, on cross examination, Dr. 1 acknowledged that material in the residency file refreshed his recollection of the Applicant's conduct while the Applicant was in the residency program. (T. 323-26.) At the November 11, 2019, CCC, according to the minutes, Dr. 3 commented the following:

> [Dr. 3] goes on to comment on how profound Dr. Akolkar's statement was. It implies that she knowingly and willing[ly] lies and that there has

> to be more to it than that. [Dr. 3] doesn't believe that Dr. Akolkar is going to walk out the door today and stop lying because this is the 3rd time she has been brought before this committee for the same reason.

(State's ex. 2 at 61.)

The Panel finds only limited value in the testimony of the witnesses the Applicant presented and relies upon the residency file over the Applicant's witnesses. The Panel denies this exception by the Applicant.

CONCLUSIONS OF LAW

Over the course of several years and numerous rotations at several different hospitals, the Applicant consistently demonstrated severe deficiencies in her medical skill and judgment. The Applicant was repeatedly ill-prepared to treat her patients, often failing to read the results of testing performed on patients. But most concerning is that the Applicant established a pattern of misleading attendings on the conditions of their patients.

As early as June 2016, an attending physician wrote an Early Warning Note to the residency Program Director about the Applicant, stating, "Lying about details related to patient care to the chief & attending. Decisions were being made about patient care based on information being provided which was not correct." Two years later, in March 2018, the Applicant failed to check crucial results from an x-ray and from the laboratory, which resulted in misdiagnosing a foot wound as a foot ulcer with poor arterial inflow, instead of the condition the patient had, which was a necrotizing infection with tissue gangrene. The patient required an emergency below the knee amputation due to the infection. The following year, in August 2019, a patient with a gallstone had an ERCP performed, but the Applicant did not read the results. When asked about the results by the attending, the Applicant, rather than admitting that she had not read the results of the ERCP, dishonestly reported to the attending that the stone had passed. The patient was thus scheduled for

another procedure: a laparoscopic cholecystectomy (removal of the gallbladder). The patient was brought to the operating room and anesthetized, but the attending called the gastrointestinal department to verify the results of the ERCP and found out the stone had not passed. The patient was thus woken from the anesthesia, and another procedure was scheduled. Perhaps, even more disturbing, after misinforming the attending, the Applicant had time to read the results of the ERCP before the scheduled surgery to correct the false information she had reported, but the Applicant made no effort to do so. As described above, the Applicant's conduct constitutes unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii); professional incompetence, in violation of Health Occ. § 14-404(a)(4); and willfully making a false report in the practice of medicine, in violation of Health Occ. § 14-404(a)(11).

Further examples of professional incompetence include the incident in which, due to the Applicant's poor performance, the attending asked the Applicant to cease operating and to observe another resident complete the surgery; the Applicant's supervision of a junior resident closing a wound inappropriately with significant gaps in the wound suturing; the Applicant's difficulty in properly installing a chest tube; and the Applicant misdiagnosing an acute appendicitis. Ultimately, the Applicant was terminated from Hospital 1 and Hospital 1's surgical residency program for failure to meet core competencies and milestone required by the residency program. "In common parlance, 'incompetence' means a lack of the learning or skill necessary to perform, day in and day out, the characteristic tasks of a given calling in at least a reasonably effective way." *Blaker v. State Board of Chiropractic Examiners,* 123 Md. App. 243, 258 (1998). The Panel finds that the Applicant met this standard for incompetence and that the Applicant is professionally incompetent, in violation of Health Occ. § 14-404(a)(4).

In addition to the examples of unprofessional conduct set forth above, there are further incidents of the Applicant's unprofessional conduct including the Applicant's rudeness and dismissiveness of other members of her medical teams. For instance, during a transplant rotation, one of her patients was decompensating. The charge nurse called a transplant fellow from another division, the SICU, due to her concerns about the Applicant, which was that the Applicant did not recognize the urgency involved and had not ordered the appropriate testing. The Applicant was dismissive and rude to the nurses and the transplant fellow. The patient was transferred to SICU with shock liver and cardiac ischemia. In another incident, the Applicant was performing surgery on a patient, but the attending was concerned about how she was performing and asked a senior resident to take over. The Applicant left the operating room despite being asked by the attending to stay in order for her to learn how to properly perform the surgery. The Applicant engaged in unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii).

In sum, Disciplinary Panel B concludes as a matter of law that, based upon the findings of fact and the reasons set forth in this decision, the Applicant's actions constitute grounds to deny her Application for a license to practice medicine in Maryland, pursuant to Health Occ. § 14-205(b)(3)(i), for reasons that are grounds for action under: Health Occ. § 14-404(a)(3)(ii), Is guilty of unprofessional conduct in the practice of medicine; Health Occ. § 14-404(a)(4), Is professionally, physically, or mentally incompetent; and Health Occ. § 14-404(a)(11), Willfully making or filing a false report or record in the practice of medicine.

DENIAL OF APPLICATION FOR MEDICAL LICENSURE IN MARYLAND

Under § 14-205(b)(3)(i) of the Health Occupations Article, the Panel may deny a license to an applicant for reasons that are grounds for action under § 14-404 of the Health Occupations Article. The Panel has found reasons that are grounds for action under § 14-404, specifically under

§ 14-404(a)(3)(ii), (4) and (11), which grounds the Panel has concluded were violated by the Applicant. The question now is whether the Applicant's application for medical licensure in Maryland should be denied.

The Panel is keenly aware of how arduous residency program are. Due to the complexity and amount the work, it is usually of no great surprise when a resident makes a mistake. That being said, the Applicant is in another category. The nature of her disturbing conduct extends well beyond technical deficiencies, which the Applicant also amply demonstrated. Most troubling is her pattern of misleading attendings on patients' conditions. Instead of admitting that she did not know crucial information about a patient, she would give information that was incorrect. In other words, at times, the Applicant placed her own interests before those of her patients. The Panel finds that the denial of the Applicant's application for a license to practice medicine in Maryland is appropriate.

ORDER

It is, on the affirmative vote of a majority of the quorum of Disciplinary Panel B, hereby:

ORDERED that the Application of Applicant **NAMITA AKOLKAR, M.D.** for a license to practice medicine in Maryland, is **DENIED**; and it is further

ORDERED that this Final Order is a public document. *See* Md. Code Ann., Gen. Prov. § 4-333(b)(6).

06/14/2022
Date

Signature On File

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians

NOTICE OF RIGHT TO APPEAL

Pursuant to § 14-408(a) of the Health Occupations Article, the Applicant has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review must be filed in court within 30 days from the date this Final Decision and Order was sent to the Applicant. The Final Decision and Order was sent on the date that it was issued. The petition for judicial review must be made as directed in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222, and Maryland Rules 7-201 *et seq.*

If the Applicant petitions for judicial review of this Final Decision and Order, the Board is a party and should be served with the court's process. Also, a copy of the petition for judicial review should be sent to the Maryland Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215. In addition, the Applicant should send a copy of the petition for judicial review to the Board's counsel, David Wagner, Assistant Attorney General, Office of the Attorney General, 300 W. Preston Street, Suite 302, Baltimore, Maryland 21201 and by email at david.wagner@maryland.gov. The administrative prosecutor is not involved in the circuit court process and does not need to be served or copied on pleadings filed in circuit court.