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| **IN THE MATTER OF** | * | **BEFORE THE** |
| **NAGINA O. MALGURIA, M.D.** | * | **MARYLAND STATE** |
| **Respondent** | * | **BOARD OF PHYSICIANS** |
| **License Number: D81766 (Expired)** | * | **Case Number: 2222-0139** |

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## ORDER OF DEFAULT

On March 24, 2023, Disciplinary Panel B of the Maryland State Board of Physicians ("Board") charged Nagina O. Malguria, M.D., ("Dr. Malguria" or "the Respondent") with unprofessional conduct in the practice of medicine, in violation of Md. Code Ann., Health Occ. § 14-404(a)(3)(ii). On June 27, 2023, the case was referred to the Office of Administrative Hearings ("OAH") for an evidentiary hearing.

On August 2, 2023, OAH sent a notice to the parties that a Scheduling Conference would be held on September 14, 2023, at 9:30 a.m., by video-conference. The scheduling notice was sent to Dr. Malguria at her address of record. It was returned as undeliverable. On September 1, 2023, Dr. Malguria emailed one of the administrative prosecutors, informing the prosecutor that she was not in the United States and would not be able to attend the meeting on September 15th due to a pressing family issue. That same day, the administrative prosecutor responded by email advising Dr. Malguria that the Scheduling Conference was scheduled for September 14 and not September 15 and that she could attend remotely. The email advised Dr. Malguria to review the OAH Notice of Remote Scheduling Conference for instructions. On September 1, Dr. Malguria replied to the administrative prosecutor by email that she would be in a part of the world with limited

internet access that entire week. Dr. Malguria did not make any requests to OAH to postpone the September 14, 2023 remote Scheduling Conference. On September 14, 2023, at 9:48 a.m., the Administrative Law Judge ("ALJ") commenced the Scheduling Conference by video-conference, approximately eighteen minutes after the scheduled start time. The administrative prosecutor appeared on behalf of the State. Dr. Malguria did not appear, nor did anyone appear on her behalf. During the Scheduling Conference, a Remote Prehearing Conference was scheduled for October 18, 2023, at 9:30 a.m., via video-conference.

Following the Scheduling Conference, on September 22, 2023, OAH sent a Notice of Remote Prehearing Conference to the parties that notified the parties that a Prehearing Conference would be held on October 18, 2023, at 9:30 a.m., by video-conference. The Notice of Prehearing Conference informed Dr. Malguria that the failure to appear or to give timely notice of her inability to appear at the Prehearing Conference could result in a decision against her. The Notice was mailed to Dr. Malguria's Maryland address of record, and it was also emailed to Dr. Malguria at the email address she used to correspond with the administrative prosecutor. The mailed copy was not returned as undeliverable.

On October 1, 2023, Dr. Malguria emailed the ALJ's assistant, the administrative prosecutor, and a second administrative prosecutor on the case, confirming that Dr. Malguria's address of record was correct and informing the ALJ and the administrative prosecutors that "[t]he evidence I have pertaining to sensitive patient care issues and expert witnesses cannot be revealed at this time." She informed OAH that "I have be advi[s]ed

to not attend this webinar and focus on preparing for tasks to be completed for protecting and informing the patient population of Maryland" because "[t]he vulnerable and sick population of Maryland, the world and the United States deserves a fair and impartial presentation of how patient issues are dealt with in the medical profession and the governing bodies; efforts if any made to prevent the information from being revealed; as well as all the pertaining ethical issues." Dr. Malguria did not request a postponement of the Prehearing Conference and did not submit a prehearing statement in advance of the Prehearing Conference, as instructed.

On October 18, 2023, the ALJ held the Remote Prehearing Conference. The administrative prosecutors appeared on behalf of the State. Dr. Malguria did not appear. After waiting twenty minutes for Dr. Malguria, until 9:50 a.m., the ALJ commenced the Prehearing Conference. The ALJ noted that Dr. Malguria did not appear at the Scheduling Conference and that the notice of the Prehearing Conference was sent to Dr. Malguria by email and regular mail. The ALJ noted that Dr. Malguria confirmed through email that the address where the notices were sent was the correct address. The ALJ noted that she informed OAH that she was not going to participate due to concerns about patient confidentiality and medical profession in general, demonstrating that she had received the email scheduling order. The ALJ concluded that Dr. Malguria received proper notice of the Prehearing Conference because she received the email, and because the notice of the prehearing conference was sent to the only mailing address of record that Dr. Malguria confirmed was correct. The ALJ further confirmed that Dr. Malguria's communication

with OAH via email demonstrated that the email address was correct and that Dr. Malguria was receiving emails regarding the scheduling of the Prehearing Conference. The State made a motion for a default against Dr. Malguria.

Under OAH's rules of procedure, "[i]f, after receiving proper notice as provided in Regulation .05C of this chapter, a party fails to attend or participate, either personally or through a representative, in a Prehearing Conference, hearing, or other stage of a proceeding, the ALJ may proceed in that party's absence or may, in accordance with the hearing authority delegated by the agency, issue a final or proposed default order against the defaulting party." COMAR 28.02.01.23A.

On October 27, 2023, the ALJ issued a Proposed Default Order. The ALJ found that Dr. Malguria had proper notice of the October 18, 2023, Remote Prehearing Conference and that she failed to appear or participate. The ALJ proposed that the Panel find Dr. Malguria in default, adopt as findings of fact the statements set forth in the allegations of fact section of the charges, and conclude as a matter of law that Dr. Malguria violated Health Occ. § 14-404(a)(3)(ii). The ALJ did not propose a sanction.

The ALJ mailed copies of the Proposed Default Order to Dr. Malguria, the administrative prosecutor, and the Board at the parties' respective addresses of record and emailed a copy to the same email address that Dr. Malguria had used for correspondences. The Proposed Default Order notified the parties that they may file written exceptions to the proposed order but must do so within 15 days of the date of the Proposed Default Order. The Proposed Default Order stated that any exceptions and requests for a hearing must be

sent to the Board with a copy provided to the opposing party. On October 31, 2023, the Board also emailed Dr. Malguria notice of the exceptions process. Neither party filed exceptions. On January 10, 2024, this case came before Disciplinary Panel A ("Panel A") of the Board for final disposition.

## FINDINGS OF FACT

Because Panel A concludes that Dr. Malguria has defaulted and has not filed exceptions to the ALJ's Proposed Default Order, the following findings of fact are adopted from the allegations of fact in the charging document and are deemed proven by the preponderance of the evidence:

### I. Background/Licensing Information

1. At all relevant times, the Respondent was a physician licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on May 20, 2016, under License Number D81766. The Respondent failed to renew her license during the 2023 renewal period.[1]

2. The Respondent is board-certified in diagnostic radiology.

3. At all relevant times, the Respondent was employed as a radiologist at a health care facility (the "Facility")[2] located in Maryland. The Respondent practiced at the Facility from on or about July 1, 2016, until on or about February 7, 2022, when the Facility summarily suspended her medical staff membership and clinical privileges (*see* ¶ 4, *infra*).

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[1] The Respondent's license expired on September 30, 2023. Pursuant to Health Occ. § 14-403(a), the Board retains jurisdiction over the Respondent because a license "may not lapse by operation of law while the individual is under investigation or while charges are pending."

[2] For confidentiality reasons, the Facility and the individuals referenced in this document will not be identified by name.

## II. Mandated 10-Day Report

4. On or about February 18, 2022, the Board received a Mandated 10-Day Report (the "Report") from the Facility, which notified the Board that effective February 7, 2022, it summarily suspended the Respondent's medical staff membership and clinical privileges.

5. The Facility Report stated,

> [o]n January 26, 2022, [the Respondent] failed to flag and document a "critical finding" and alert the appropriate providers in compliance with [Facility] policy. Summary suspension of [the Respondent's] medical staff membership and clinical privileges was instituted to reduce the substantial likelihood of imminent injury to patients, based on this event, [the Respondent's] response to this concern, and a lack of effective responses by [the Respondent] to interventions, coaching, and retraining when prior concerns were identified.

## III. Board Investigation

6. After reviewing the above Report, the Board initiated an investigation of this matter. As part of its investigation, the Board obtained the Respondent's written response to the allegations that were set forth in the Report; obtained the Respondent's quality assurance/risk management ("QA/RM") file from the Facility; obtained pertinent medical records; and conducted under-oath interviews of the Respondent and professional colleagues with knowledge of this matter.

***Respondent's written response to the Report***

7. By letter dated May 17, 2022, the Board notified the Respondent that it had initiated an investigation of this matter. The Board provided the Respondent with a copy of the Report and requested that she address the matter in a written response.

8. By letter dated June 1, 2022, the Respondent responded, alleging that the Facility's actions against her were the result of a "systematic pattern of bullying, lack of interest in patient and clinical care and elaborate efforts spent in pursuing personal agendas by any diabolical means, particularly by several senior members of the staff."

9. The Respondent claimed that the Facility's suspension of her privileges was retaliatory and that she was "targeted, by this prevalent manipulative highlevel (sic) attitude, the motivation being the same desperate 'greed thinking' that lead (sic) to thousands of inappropriate billing codes per year."

10. The Respondent also addressed allegations that she failed to note critical findings in a January 26, 2022, CT report and failed to document communicating with ordering providers from the emergency department ("ED"), which caused the Facility to summarily suspend her clinical privileges. The Respondent acknowledged that she failed to document a critical finding in the CT report, stating, "I chose to move forward without the 'critical results tab.'"

11. The Respondent further stated that she was busy on the afternoon of January 26, 2022, and that "[w]hile adherence with the rules and policies is absolutely a preference, sometimes, as physicians we make decisions towards acting in patient interests over doting (sic) the Is and the Ts and this was one of the moments."

***The Facility's summary suspension of the Respondent's Privileges***

12. The Facility's QA/RM file stated that the Facility began having concerns about the Respondent's professionalism and performance after her staff appointment in 2016. The Facility noted that from 2016 onward, it had concerns about the Respondent's: interpretation of some examinations, especially vascular and cardiac studies; lack of availability to clinical staff; unresponsiveness to email, text, and secure chat for urgent patient care matters; and response to feedback and attempted interventions, education and coaching. The Facility further noted that in or around December 2021, it imposed practice limitations on the Respondent.

13. The Facility investigated the Respondent's actions with respect to her failure to document a critical finding in the January 26, 2022, CT report, her failure to communicate with the ordering providers about her findings, and her failure to document those communications.

14. The CT report was for a 72-year-old man who was transported by emergency medical services on January 26, 2022, to the Facility's ED with symptoms including slurred speech, chest and back pain, and shortness of breath of 48 hours' duration. At around 3:19 p.m., an ED physician ordered a chest, abdomen and pelvis CT with IV contrast for the patient. The study was completed at around 4:13 p.m. At around 4:30 p.m., an ED physician contacted the radiology department and spoke to a radiology fellow (the "Fellow")[3] who was then on duty. The ED physician requested that the Fellow open the

[3] At the time, the Fellow was on staff at the Facility and was a Maryland-licensed physician. For confidentiality reasons, the Fellow's name will not be identified in this document.

study and interpret it in real time. The Fellow made a preliminary interpretation of the study and communicated his findings to the ED physician. The Fellow then informed the ED physician that he needed to review the study further and dictate a report.

15. At around 4:45 p.m., the Fellow dictated a preliminary report, which did not include a critical finding flag or documentation of a discussion of the findings with the ordering provider(s) from the ED. When interviewed during the Facility investigation, the Fellow stated that he was unsure of his findings and attempted to discuss them with the Respondent, who was also on duty and in the reading room. The Fellow stated that he was unable to confer with the Respondent because she was distracted and on the telephone with a bank for almost an hour.

16. At around 5:45 p.m., the Respondent reviewed and signed the CT report after making a minor change to lung findings and removing one sentence from the body of the report. The Respondent did not discuss the images with the Fellow or critical findings and communications documentation. The Respondent signed the final report without including a critical finding flag or documenting that any discussions occurred with anyone from the ED. The patient expired at around 1:31 a.m. on January 27, 2022.

17. On or about February 1, 2022, a senior Facility physician ("Physician-1") contacted the Respondent to address the matter with her after learning that the patient had died, and the Respondent did not place critical findings documentation in the final report. Physician-1 emailed the Respondent and questioned why she failed to include the required critical findings documentation and documentation of her communication of those critical

findings to ED physicians. In an email reply, the Respondent acknowledged that personnel from the ED contacted the Fellow, who had started reviewing the study, and that the Fellow asked her for confirmation of the findings. The Respondent further stated, "I see the documentation of the discussion/Critical findings is not at the end of the report and I accept the lapse. It was one of those things that in the rush of the moment, the priority seemed to be get the report out there and so I just didn't check the Critical finding documentation."

18. On or about February 2, 2022, the Respondent sent a follow-up email to Physician-1, this time stating, "I have had an opportunity to think about this a little more and would like to retract the statement that there was any lapse on our end." The Respondent further stated, "'critical results' and 'documentation of communication' are fear-based techniques to supposedly 'protect' us, I guess when we don't trust our decisions, clinical skills or the system." (quotation marks in original)

19. On or about February 3, 2022, a group of supervisory Facility physicians convened a meeting with the Respondent to address their concerns about her review of the January 26, 2022, CT study and more globally, the quality of her work and repeated and ongoing issues the Facility had with her interpretations and responsiveness, despite Facility interventions. During the meeting, the Respondent was visibly agitated, defensive and confrontational.

20. After the meeting concluded, the Respondent, on February 3 and 4, 2022, sent a series of unprofessional and threatening emails to some of the attendees of the meeting, including Physician-1 and the senior supervisory Facility physician ("Physician-

2") who presented case findings at the meeting. In these emails, the Respondent, among other things, denigrated the Facility's review process and personally ridiculed Physician-1 and Physician-2 and their participation in that review process. The Respondent also threatened committee members with expensive litigation costs and went so far as to email them a copy of her bank statement to notify them of her resources for that purpose.

21. For example, in an email to the committee members, sent at 3:00 p.m. on February 3, 2022, the Respondent disputed the committee's findings and concluded her email as follows:

> This has been a systematic pattern of distortions and manipulations of delicate patient care issues with self-serving vengeance and vendetta and complete lack of compassion for true patient care issues. FYI, full disclosure, I am very, very rich; I paid for my condo . . . in cash . . . and have tons of spare cash. Happy to share a screen shot of my checking account, so you know I am serious. Will not be in the least bit financially inconvenienced by any media/legal drama.

22. The Respondent sent an email to the committee members at 3:09 p.m. on February 3, 2022, in which she attached a screenshot of her bank account balance.

23. The Respondent sent an email to the committee members at 4:05 p.m. on February 3, 2022, stating in part:

> In case, it is not clear, why would I share these personal details, that is the amount I will enjoy spending on the media/legal circus without wincing because I dont (sic) have to break any investments etc.
>
> Just thought I would clarify, in case anyone does not get where this is going.
>
> Some people (including our buddy [name redacted]), suggested I use a lawyer recommended by [the Facility], which makes me think that

> people involved are too bright (sic). Why would I use a lawyer suggested by you to go after you?
>
> D...uuuuuuuhhH!!!!!!!!!!!

24. After Physician-2 responded by email to the Respondent by again restating the basis of the committee's findings, the Respondent emailed a reply at 5:37 p.m. to Physician-2 and other committee members. The Respondent stated to Physician-2 as follows:

> I am not certain whether it is just you or has been directed by you, but as you are very well aware, I have documentation of random vindictive behaviors; and more concerning to the lay public, complete lack of remorse or regret for such actions, that affect patient care.
>
> As I also explained and demonstrated documentation, I will easily pay up to $400,000 in personal/legal/media/social media coverage to bring this all to light.
>
> These are complex issues, I need good counsel and will almost certainly not have been able to choose appropriate counsel by 2.00 (sic) tomorrow. If you act in any way that hurts my career, till I have made a decision; I will have no hesitation in taking the most aggressive counter-action, against you personally, any individual that supports you, or an entire institutrion (sic), if I have to.
>
> Sorry, this cancel-culture times, highly unwantred (sic); by sorry, the days of inapappropriate (sic) power games have ended.

25. The Respondent then sent an email to Physician-2 and other committee members at 8:05 a.m. on February 4, 2022, stating, "I have learnt (sic) that your name is very fortuitous and you are a fitting personality for a social media personality name that does not have a face yet." The Respondent stated that the committee's accusations were "delusional and false." The Respondent then addressed Physician-1 by stating that

Physician-1's "actions are not in accordance with the laws of Karma. I might have to '**educate**' your colleagues about some simple Universal laws, but if thats (sic) not happening, thats (sic) not happening. Ill (sic) have to find some crazy way to educate." (bolding and quotation marks in original)

26. The Respondent sent an email to Physician-2 and other committee members at 8:31 a.m. on February 4, 2022, in which she ridiculed Physician-2 about her first name and ridiculed Physician-1 in a similar manner.

27. Physician-2 responded to the Respondent's email, after which the Respondent sent an email reply to Physician-2 and other committee members at 11:12 a.m. on February 4, 2022. In part, the Respondent stated,

> "It's on [Physician-2's first name redacted]. You will certainly be hearing from me. The response will come, may or may not be the way you expect to see it. Super excited! Know that this is a fight to the death for me, win or lose doesnt (sic) matter, its (sic) on! Wealth, possessions, reputation none of it matters when a righteous fight come (sic) up."

28. The Respondent then sent an email to Physician-2 and other committee members at 3:00 p.m. on February 4, 2022, stating,

> Got me to peek [named redacted] with your silly phone message. I was not going to log into this cracker box palace, but you made me!
>
> * * *
>
> Since you are so predictable, may I suggest that you brace yourself for a mass mental health crisis soon. I dont (sic) think that any of you have the emotional capacity to comprehend what is coming and you may want to start tapping into all the resources that may be available to you. May need to think outside the box a bit; there seems to be expertise perfectly capable of anticipating your current moves.

29. By letter dated February 7, 2022, the Facility notified the Respondent of its summary suspension of her clinical privileges, stating that it was taking such action to reduce the substantial likelihood of imminent injury to patients. The Facility stated that its concerns were related to her "recent failure to flag and document a 'critical finding,' and alert the appropriate providers, in combination with a history of repeated failures to appropriately interpret some radiologic studies and follow stated Department policies." The Facility further notified the Respondent that it would convene a special committee and would afford her the opportunity to attend the meeting and present oral argument in opposition to the continuation of the suspension. The Facility subsequently notified the Respondent that the committee meeting would take place on February 9, 2022. The Respondent declined to attend the meeting, however.

***Board interviews***

30. The Board conducted a series of under-oath interviews of practitioners who were involved in or had knowledge of the January 26, 2022, matter.

**The Fellow**

31. In his interview, the Fellow confirmed that he preliminarily reviewed the CT report and verbally notified the Respondent that he needed to review the scan with her but that she was on an extended telephone call discussing a financial matter. The Fellow stated that the Respondent signed off on the study without speaking to him or speaking or communicating with the ordering providers. The Fellow stated that the Respondent

communicated with him after concerns arose about her interpretation of the scan and that she acknowledged that the CT findings should have been relayed to the ordering providers.

**Physician-2**

32. When interviewed, Physician-2 stated that the Respondent failed to follow Facility policies with respect to the January 26, 2022, scan, which would have included flagging the CT report, noting the time of the review, communicating with the ordering providers, and noting the time she communicated with those providers and the name of the person with whom she communicated.

33. Physician-2 noted prior concerns about the Respondent's performance and professionalism dating back to 2016, including her interpretation of vascular and cardiac studies and her failure to respond to telephone, email and beeper messages. Physician-2 stated that the Respondent failed to accept responsibility for her performance lapses and did not sufficiently respond to the Facility's remediation efforts. Physician-2 stated that the Respondent's performance issues and unavailability were so serious that in or around December 2021, the Facility imposed practice limitations on her.

34. Physician-2 stated that with respect to the January 26, 2022, CT scan report, the Fellow informed Physician-2 that he attempted to speak to the Respondent about the CT study but that the Respondent was distracted and did not communicate with him but signed off on the report. Physician-2 stated that it was the Respondent's responsibility to place the critical finding documentation on the report and communicate with the ordering provider(s) and document those discussions in the report.

35. Physician-2 stated that during the meeting with Facility physicians on February 3, 2022, the Respondent was dismissive of the Facility's concerns, did not accept responsibility for her actions and was argumentative. Physician-2 also acknowledged concerns after receiving a series of threatening emails from the Respondent after the February 3, 2022, meeting, to the extent that Physician-2 notified Facility security officials.

**Physician-3**

36. Physician-3, another senior Facility physician, was also on the committee that reviewed the January 26, 2022, CT incident. Physician-3 stated that under the circumstances, it was the radiologist's responsibility to notify the ordering practitioner of any critical findings and document the notification in the CT report. Physician-3 stated that he received some of the Respondent's emails from February 3-4, 2022, and considered them to be "hostile" and "sad."

**The Respondent**

37. When interviewed, the Respondent acknowledged that the Fellow notified her of a concerning finding on the January 26, 2022, CT scan that she determined was critical. The Respondent further stated that the Fellow's report did not contain a critical finding flag and that she did not contact or speak to the ED providers and did not follow the "exact clerical requirements." The Respondent admitted that it was a lapse not to document the critical finding in the report.

38. The Respondent characterized her meeting with senior Facility practitioners as a "bullying session . . . [and] an opportunity to pick on me."

39. With respect to the emails she sent to senior Facility practitioners, the Respondent characterized them as "counter-threats . . . [and that] . . . after a while, you have to stand up to the bullies, and this was just me standing up to the bullying." The Respondent did acknowledge that she sent a screenshot of her bank account holdings to Physician-2 and other senior Facility practitioners. When asked if she could see how the physicians she emailed could have felt threatened by those emails, the Respondent stated, "I probably did lash back, but it was probably just juvenile and petty."

## CONCLUSIONS OF LAW

Panel A finds Dr. Malguria in default based upon her failure to appear or participate at the Remote Prehearing Conference scheduled for October 18, 2023 at OAH. *See* State Gov't § 10-210(4). Based upon the foregoing findings of fact, Panel A concludes that Dr. Malguria is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii).

## SANCTION

Based on the entirety of the findings of fact, Panel A concludes that Dr. Malguria's license to practice medicine in Maryland should be revoked.

## ORDER

It is, on the affirmative vote of a majority of the quorum of Panel A, hereby

**ORDERED** that the license of Nagina O. Malguria, M.D. to practice medicine in Maryland is **REVOKED;** and it is further

**ORDERED** that this is a public document. *See* Health Occ. §§ 1-607, 14-411.1(b)(2), and Md. Code Ann., Gen. Prov. § 4-333(b)(6).

02/27/2024
Date

***Signature On File***

Christine A. Farrelly, Executive Director
Maryland State Board of Physicians

**NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW**

Pursuant to Md. Code Ann., Health Occ. § 14-408, Dr. Malguria has the right to seek judicial review of this Order of Default. Any petition for judicial review shall be filed within thirty (30) days from the date of mailing of this Order of Default. The cover letter accompanying this Order indicates the date the decision was mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Dr. Malguria files a petition for judicial review, the Board is a party and should be served with the court's process at the following address:

**Maryland State Board of Physicians**
**Christine A. Farrelly, Executive Director**
**4201 Patterson Avenue**
**Baltimore, Maryland 21215**

Notice of any petition should also be sent to the Board's counsel at the following address:

**David Finkler**
**Assistant Attorney General**

**Maryland Department of Health**
**300 West Preston Street, Suite 302**
**Baltimore, Maryland 21201**