IN THE MATTER OF	*	**BEFORE THE**
JOHN L. YOUNG, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D23121		**Case Number: 2012-0497**

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

ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

The Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of John L. Young, M.D., (the "Respondent") (D.O.B. 07/25/1951), license number D23121, to practice medicine in the State of Maryland. The Board takes such action pursuant to its authority under Md. State Govt Code Ann. § 10-226(c)(2009 Repl. Vol.) concluding that the public health, safety or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

Based on information received by, and made known to the Board, and the investigatory information obtained by, received by and made known to and available to the Board, including the instances described below, the Board has reason to believe that the following facts are true:[1]

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on February 15, 1979. The Respondent also holds active licenses in the following states: Florida; Illinois; Indiana; Kentucky;

[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with notice of the basis of the suspension. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

Missouri; Pennsylvania and Washington. The Respondent holds an inactive license in California, the District of Columbia and Virginia.

2. The Respondent is board-certified in obstetrics and gynecology.

3. From 1980 until April 2011, the Respondent had been medical practice partners with Mark R. Geier, M.D.

4. The Board initiated an investigation of the Respondent based upon concerns regarding his practice subsequent to the Board's summary suspension and revocation of Dr. Geier's license to practice medicine in Maryland.

Dr. Mark Geier

a. Summary Suspension

5. Effective April 27, 2011, the Board summarily suspended Dr. Geier having concluded that the public health, safety or welfare imperatively required such emergency action. State Gov't § 10-226(c)(2). The Board suspended Dr. Geier after concluding that his practice of administering Lupron,[2] a powerful anti-androgen, and chelation to autistic children whom he failed to examine and monitor adequately raised a substantial likelihood of risk of serious harm to the public health, safety or welfare.

6. On May 12, 2011, the Board reaffirmed Dr. Geier's summary suspension, subject to his right to request a full evidentiary hearing before an Administrative Law Judge ("ALJ") of the Office of Administrative Hearings ("OAH").

[2] The trade name of leuprolide acetate. Dr. Geier's Lupron treatment regimen consisted of daily subcutaneous ("SQ") injections of Lupron (typically indicated on prescriptions as "leuprolide acetate solution") and bi-weekly intramuscular ("IM") injections of Lupron (typically indicated on prescriptions as "Lupron Pediatric Depot"). When interviewed by Board staff, the Respondent stated that Lupron is a long-acting form of the medication and leuprolide is the short-acting version.

7. In a Proposed Decision dated September 26, 2011, the ALJ proposed that the Board's Summary Suspension Order be upheld.

8. By Final Decision and Order dated March 22, 2012, the Board ordered Dr. Geier's Summary Suspension to be upheld pending resolution of charges that Dr. Geier had violated the Maryland Medical Practice Act. In the Final Decision and Order, the Board held:

> The ALJ concluded that 'allowing [Dr. Geier] to continue practicing medicine while formal charges are pending raises a substantial likelihood of risk of serious harm to the public health, safety, or welfare.' The Board entirely agrees. For Dr. Geier to practice medicine at this time would constitute a danger to the patient community.

Final Decision and Order (Summary Suspension) at 9

b. Charges Under the Maryland Medical Practice Act

9. On May 16, 2011, the Board charged Dr. Geier with numerous violations of the Medical Practice Act related, *inter alia,* to his administration of Lupron and chelation to autistic children in the absence of proper evaluation and monitoring.

10. On March 12, 2012, after a five-day evidentiary hearing, the ALJ concluded that Dr. Geier had violated the standard of quality care as well as other provisions of the Maryland Medical Practice Act.

11. On August 22, 2012, the Board issued its Final Decision and Order in which Dr. Geier's license to practice medicine in Maryland was revoked.

12. With regard to Dr. Geier's administration of Lupron to autistic children, the Board held in pertinent part:

> The ALJ made findings that Lupron therapy may have been medically beneficial. (citation omitted) These findings are questionable, in the Board's opinion, because Dr. Geier did not even properly evaluate whether the treatment was effective. The

> ALJ made these findings about the effectiveness of Lupron therapy primarily based on the testimony of the parents, but the testimony was unsupported by any adequate documentation in the medical records. (Footnote omitted) The Board does not believe that this is the appropriate methodology to evaluate the possible effectiveness of Lupron. (Footnote omitted) Nor does the Board adopt the ALJ's findings that determining the Tanner Stage of these patients was irrelevant. (Footnote omitted)...The evidence of the safety of this treatment was, in the Board's opinion, insufficient to justify the dismissal of this serious concern. However, it is not necessary to make finding on the value of this off-label use of Lupron...because Dr. Geier in any case egregiously violated basic medical standards in his treatment of these patients by not evaluating them properly...and failing to evaluate in any realistic medical way whether his intensive and very expensive treatment was effective.

Final Decision and Order (Charges) at 6 - 7

13. The Board's Conclusions of Law included the following:

> By failing to properly evaluate patients before treating them with an intensive regimen of drug therapy...by failing to properly evaluate whether his treatment was working...Dr. Geier failed to meet the standard of quality care[.]
>
> By failing to document adequately the reasons these treatments were initiated, halted or modified, by failing to maintain clear evidence of informed consent, or even in some cases failing to document even the manner in which the patients were contacted, Dr. Geier failed to keep adequate medical records[.]
>
> ...
>
> His violations of the standard of care, especially his treating of some patients without examining them and reaching diagnoses in the absence of required diagnostic tests, were so egregious as to amount to professional conduct in themselves. (Footnote omitted)

Final Decision and Order (Charges) at 8 – 9

14. The Board revoked Dr. Geier's medical license for reasons including the following:

> Dr. Geier has displayed in this case an almost total disregard of basic medical and ethical standards by treating patients without examining or diagnosing them [and] continuing treatment without properly evaluating its effectiveness...Dr. Geier made little use of those methodologies that distinguish the practice of medicine as a profession. At the same time, he profited greatly from the minimal

> efforts he made for these patients. In plain words, Dr. Geier exploited these patients under the guise of providing competent medical treatment. Such a use of a medical license is anathema to the Board. The Board has no hesitation in revoking his medical license. (Footnote omitted)

Final Decision and Order (Charges) at 14 – 15

The Respondent's Dispensing Permit

15. On August 15, 2011, the Respondent completed an "Application for Physician's Permit to Dispense Prescription Drugs."

16. On September 12, 2011, the Board issued to the Respondent a Permit to Dispense Prescription Drugs ("dispensing permit").[3]

17. All of the patients at issue here reside in states other than Maryland. Pharmacy surveys reveal that many prescriptions written by the Respondent for Lupron and leuprolide were dispensed from the Respondent's office in Rockville, Maryland.[4]

The Board's Investigation

18. Based upon its concerns regarding the Respondent's prescribing practices, on or about January 23, 2012, the Board issued to a pharmacy benefits management company ("PBM"), a subpoena *duces tecum* for claims submitted by the Respondent and reimbursed under the Respondent's Drug Enforcement Administration ("DEA") number from 2009 to the date the subpoena was issued.

19. On or about January 27, 2012, the Board received from the PBM a spreadsheet in response to the Board's subpoena. The information revealed that the

[3] The Respondent's dispensing permit expires effective September 10, 2016.

[4] Some prescriptions written by the Respondent were dispensed from Dr. Geier's home address. The Respondent advised Board staff that he did not practice at that location.

Respondent prescribed and dispensed leuprolide and Lupron to patients beginning in February 2011.[5] (*see specifically*, Patient A, ¶ ¶ 39 - 44, below).

20. On February 3, 2012, the Board issued to the Respondent a subpoena *duces tecum* for 15 medical records of patients who appeared on the PBM spreadsheet.[6]

21. On July 20, 2012 the Respondent, through counsel, transmitted 12 patient records to the Board.[7]

22. By letter dated September 6, 2012, the Board requested the Respondent to provide a written summary of his care of each patient.

23. By letter dated September 12, 2012, the Respondent provided to the Board his written summaries of care.

24. On October 31, 2012, the Respondent, accompanied by counsel, was interviewed under oath by Board staff.

25. On or about November 26, 2012, the Board issued a subpoena to the PBM for an updated run of the Respondent's prescribing activities.

26. On or about December 10, 2012, the Board received the PBM's response to the subpoena. The response revealed that the Respondent prescribed Lupron or leuprolide to patients through November 19, 2012.

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[5] The Respondent did not obtain his dispensing permit until September 12, 2011.
[6] The Respondent, through counsel, had filed in the Circuit Court of Montgomery County to quash the Board's subpoena. By Order dated July 9, 2012, the Respondent was ordered to comply with subpoena.
[7] The Respondent transmitted records for 12 pediatric patients included in the subpoena. He notified the Board that he did not maintain records for the three (3) adult patients whose records had been requested.

Board Interview

27. During the Respondent's October 31, 2012 interview, Board staff asked patient-specific questions and inquired about the nature of the Respondent's working relationship with Dr. Geier before and after Dr. Geier's license was suspended.

28. During the interview the Respondent acknowledged that Dr. Geier had informed him in April 2011 that his medical license had been suspended.

29. The Respondent told Board staff that he had "occasionally" prescribed Lupron before Dr. Geier's suspension in April 2011; that his involvement was "extremely sporadic" and that "[Dr. Geier] was partaking of that activity while I was still concentrating on doing prenatal genetics...it wasn't the focus of paying any attention to that practice until May." The Respondent further stated that he had had no input into Dr. Geier's office procedures and policies.

30. The Respondent acknowledged that he had not obtained a dispensing permit prior to his August 2011 request. When Board staff asked the Respondent why he had obtained a dispensing permit for the first time in August 2011, the Respondent replied, "[i]n case I wanted to dispense certain medications to some patients."

31. During the interview, the following exchange took place:

> Q: Did you ever dispense or prescribe medications for Dr. Geier's patients based on his recommendation, directly to you, after he lost his privilege to practice medicine in the State of Maryland?
>
> A: Yes.

32. The Respondent further stated that he prescribed to some of Dr. Geier's patients based on Dr. Geier's recommendations after Dr. Geier's license had been suspended. The Respondent stated that it was, "just picking up [Dr. Geier's] patients and, you know, pursuing their care when ---when he lost his license."

33. The Respondent also stated that his communication with Dr. Geier included the dosage of Lupron to be prescribed to specific patients.

34. The Respondent acknowledged that he asked Dr. Geier questions when treating patients he had not previously seen and for whom he was continuing Dr. Geier's treatment:

> ...most of these patients are his, he's followed them and in many cases for an extended period of time. So, he would know the background much better.
>
> Second of all, ...as his partner of over 30 years, his professional opinion, his – his personal ethics, his involvement in this entire field for the last ten years or so, his numerous publications and speaking, I would consider that he would have a lot of expertise in this whole thing and I certainly would respect and, you know, solicit his opinions on some –a lot of this care.
>
> And I've seen a lot of the positive results he's received from these patients—almost uniformly his patients are desperate and, you know, great stress in the entire family *(sic)*, and I've seen how he's benefitted many of them...
>
> So I've seen it, you know, directly where, you know, the success and advocacy of his treatment *(sic).*

The Board'sTelemedicine Regulations

35. All of the patients at issue here and to whom the Respondent prescribed Lupron reside in a state other than Maryland.

36. Effective January 13, 2011, the Board promulgated regulations pertaining to telemedicine at Code of Maryland Regulations Title 10, Subtitle 32, Chapter 5.

37. The Board's regulations define "telemedicine" as "the practice of medicine from a distance in which intervention and treatment decisions and recommendations are based on clinical data, documents, and information transmitted through telecommunications systems.: Code Md. Regs. tit. 10, § 32.05.02B(8).

38. The Board's telemedicine regulations further provide:

> **.03 Licensure**
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> Except as specified in Health Occupations Article, §14-302, Annotated Code of Maryland,[8] an individual shall be a licensed Maryland physician in order to practice telemedicine if one or both of the following occurs:
>
> A. The individual practicing telemedicine is physically located in Maryland;
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> B. The patient is in Maryland.
>
> ...
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> **.05 Patient Evaluation**
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> A. A physician shall perform a patient evaluation adequate to establish diagnoses and identify underlying conditions or contraindications to recommended treatment options before providing treatment or prescribing medication.
>
> B. A Maryland-licensed physician may rely on a patient evaluation performed by another Maryland-licensed physician if one physician is providing coverage for the other physician.
>
> ...
>
> **.06 Standard of Quality Care**
>
> A. A physician shall ensure that the quality and quantity of data and other information is sufficient in making medical decisions.
>
> ...
>
> D. A physician practicing telemedicine shall:
>
> ...
>
> (2) Create and maintain adequate medical records;
>
> ...
>
> (4) Adhere to requirements and prohibitions found in Health Occupations Article, §§ 1-212, 1-301 – 1-306, and 14-404, Annotated Code of Maryland.[9]

[8] The licensure exceptions in this section are not applicable.

Patient-Specific Allegations

Patient A

39. Patient A, then a 16-year-old male residing in a state other than Maryland, initially presented to Dr. Geier on April 4, 2011. Dr. Geier documented in his initial assessment a diagnosis of Attention Deficit and Hyperactivity Disorder ("ADHD") with language impairment; he also noted that a diagnosis of autism spectrum disorder ("ASD") was questionable. On an undated form in Patient A's file, Dr. Geier also noted, "tent[ative] dx [diagnosis] ASD mildly aggressive."

40. On February 10, 2011, prior to Dr. Geier's assessment of Patient A, the Respondent prescribed leuprolide acetate solution ("leuprolide") 0.7 ml SQ with six refills The Respondent wrote the prescription on a form imprinted with the Rockville, Maryland address of "The Genetic Centers of America."[10]

41. On May 2, 2011, the Respondent prescribed leuprolide 2.1 ml SQ once a day. The Respondent authorized six refills of the prescription.

42. When interviewed by Board staff, the Respondent stated that the one and only time he had seen Patient A was by Skype on May 10, 2011.

43. The Respondent was unable to explain why he had written two prescriptions for leuprolide for Patient A prior to Dr. Geier's initial assessment of the patient.

44. When Board staff asked why he would have tripled Patient A's dosage of leuprolide from 0.7 ml in February 2011 to 2.1 ml in May 2011, the Respondent responded: "I obviously don't remember."

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[9] Heath Occ. § 1-212 prohibits sexual misconduct; Health Occ. § 1-301 *et seq.* pertains to patient referrals; Health Occ. § 14-404 set forth the Board's disciplinary grounds.

[10] The Respondent wrote all the prescriptions at issue here on a prescription form imprinted with the Rockville, Maryland office address.

Patient B

45. Patient B, a then 10-year-old male residing in residing in a state other than Maryland, was initially assessed by Dr. Geier in 2009. Patient B had been diagnosed with obsessive compulsive disorder, seizure disorder, epilepsy and "PDD" (presumably Pervasive Developmental Disorder – Not Otherwise Specified ("PDD-NOS")) by a physician other than Dr. Geier.

46. Dr. Geier had prescribed Lupron and leuprolide to Patient B.

47. The Respondent wrote two prescriptions for Lupron for Patient B: the Respondent wrote the first prescription, for leuprolide 1.2 ml SQ daily with six refills) on April 4, 2011[11] on January 11, 2012, he wrote a prescription for Lupron Pediatric Depot.

48. In his written summary of care of Patient B, the Respondent wrote:

> [Patient B and birthdate] he's a patient of Dr. Geier and Dr. Davis,[12] since August 21, 2009, with diagnosis of ASD and seizures. I never saw this patient. I wrote prescriptions for leuprolide and Lupron, April 2011 and January 2012.

49. When interviewed, the Respondent acknowledged that he had never seen Patient B and had not written any notes regarding his care.

Patient C

50. Patient C, then a 16-year-old female residing in residing in a state other than Maryland, was initially assessed by Dr. Geier in October 2010. Patient C had been diagnosed with autism and PDD-NOS in 1998 by physicians other than Dr. Geier. Dr. Geier noted that Patient C had had one seizure in 2006.

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[11] Dr. Geier had written a prescription for leuprolide acetate solution for the same dosage with six refills on March 5, 2011.

[12] Dr. Davis is an associate of Dr. Geier who practices in Illinois.

51. Several days before Patient C's initial assessment, Dr. Geier had prescribed leuprolide 0.6 ml SQ daily to her.

52. Dr. Geier increased Patient C's dosage of leuprolide from 0.6 ml daily to 0.8 ml in March 2011, noting a "mod[erate] Hg [mercury] toxicity."

53. On April 12, 2011, the Respondent wrote a prescription for Patient C for leuprolide increasing the dosage to 1.0 ml SQ daily. The Respondent did not document his treatment rationale, nor did he document a note of any kind on this date.

54. On April 20, 2011, Dr. Geier prescribed 1.0 ml of leuprolide SQ once daily Patient C.

55. On June 19, 2011, the Respondent wrote a prescription for Patient C increasing her dosage of Lupron to 1.4 ml SQ daily. The Respondent did not document a note on this date.

56. On July 28, 2011, the Respondent documented a telephone "consultation" with Patient C's mother on a form imprinted with the office address of a Genetics Consultants location outside of Maryland. The Respondent documented that he discussed switching to IM Lupron "eventually" and that Patient C's mother, "temporarily wants to cont[inue] current leuprolide." Patient C's medications were listed on the form. Her leuprolide dosage was noted to be 1.0 ml. The Respondent did not correct the dosage to conform to the prescription he had written earlier that month.

57. On November 22, 2011, the Respondent documented a telephone "consultation" with Patient C's mother in which he noted:"[w]ill cont. Lupron 1.4 ml DBL

strength." The consultation form bears the address of an office outside of Maryland. On that date, the Respondent also wrote a prescription for Lupron 1.4 ml SQ daily for Patient C.

58. When interviewed by Board staff, the Respondent stated that he did not remember why he increased Patient C's Lupron dosage from 1.0 ml to 1.4 ml daily.

Patient D

59. Patient D, then a 17-year-old female who resided in residing in a state other than Maryland, was initially assessed by Dr. Geier on December 28, 2010. Dr. Geier noted that Patient D had been diagnosed with ADHD at eight years of age by another physician. In the Impression section of his assessment, Dr. Geier noted that Patient D was an "intelligent 17 y.o. pre-college [female] with some anger management prob[lems] & premenstrual syndrome & ADHD."

60. On January 1, 2011, Dr. Geier prescribed leuprolide 0.8 ml daily SQ (with six refills) to Patient D.

61. Dr. Geier failed to document his treatment rationale for prescribing leuprolide to a teen-aged female who had not been diagnosed as autistic and whose mother did not identify any destructive or self-destructive behavior on the Autism Treatment and Evaluation Checklist ("ATEC").

62. On April 12, 2011, the Respondent prescribed leuprolide 0.8 ml SQ daily (six refills) to Patient D.

63. On May 2, 2011, the Respondent prescribed leuprolide 2.4 ml SQ daily (six refills) to Patient D.

64. The Respondent failed to document why he continued to prescribe leuprolide to Patient D who was neither autistic nor destructive/self-destructive, and he failed to document why he tripled her leuprolide dosage in May 2011.

65. In his written summary of Patient D's care, the Respondent stated: "I never saw this patient. I wrote prescriptions for leuprolide in April 2012 *(sic)* and May 2012 *(sic)*."

Patient E

66. Patient E, then a nine-year-old female who resided in residing in a state other than Maryland, was initially assessed by Dr. Geier in 2007. Patient E had been diagnosed with autism when she was two years old.

67. Dr. Geier had prescribed leuprolide SQ and Lupron IM to Patient E since 2007.[13]

68. In July 2010, Dr. Geier prescribed leuprolide 0.4 mg SQ twice daily to Patient E.

69. On April 13, 2011, the Respondent wrote a prescription continuing Patient E's leuprolide at the same dosage with six refills.

70. On May 11, 2011, the Respondent tripled Patient E's dosage of leuprolide; he increased her dosage form 0.4 mg SQ twice daily to 1.2 ml SQ twice daily.

71. The Respondent failed to document his treatment rationale for tripling Patient E's leuprolide.

72. On August 23, 2011, the Respondent wrote a prescription for "Lupron" 1.6 ml SQ (six refills) for Patient E.

73. The Respondent failed once again to document his treatment rationale for changing Patient E's leuprolide dosage. Indeed, the last documented contact with Patient E or her family was written by Dr. Geier on April 8, 2011.

[13] Patient E was one of the patients included in the Board's cases against Dr. Geier.

74. On August 24, 2011, the Respondent signed a Prior Authorization Form which was transmitted to him by Patient E's health insurance company for pre-authorization of her leuprolide. The diagnoses "central precocious puberty" and "pituitary disfunction" *(sic)* were noted on the form to support the Respondent's request for medication.

75. When questioned by Board staff with regard to the diagnosis of pituitary dysfunction, which had not been previously documented in Patient E's medical record,[14] the Respondent stated: "I assume this is my office staff reading through the chart, picking something that's closest and resembled, you know, what the chart indicates of the purpose of pre-authorization."

76. In his written summary, the Respondent stated that he "never saw this patient."

77. When interviewed by Board staff, the Respondent reiterated that he had not seen Patient E.

Patient F

78. Patient F, then a 15-year-old female who resided in residing in a state other than Maryland, was initially assessed by Dr. Geier in March 2009. In his initial assessment, Dr. Geier noted that Patient F had been diagnosed with bi-polar disorder and PDD-NOS when she was fifteen.

79. Dr. Geier did not prescribe Lupron or leuprolide to Patient F. His treatment instead focused on her autoimmune dysfunction and adrenal/pituitary dysfunction.

[14]Some earlier Prior Authorization Forms completed by Dr. Geier had indicated "testicular hyperfunction" as the supporting diagnosis for Patient E's leuprolide.

80. On July 11, 2011, the Respondent documented that he had a consultation with Patient F's mother by Skype "to review [Patient F]'s current laboratory testing and prescriptions." The Respondent noted *inter alia* that Patient F's coproporphyrin I and III levels were high.[15] The Respondent further noted: "[s]tart leuprolide 0.7 mg DBL – check with David."[16]

81. Pharmacy surveys reveal, however, that the Respondent first prescribed leuprolide to Patient F three months earlier, in April 2011. The Respondent failed to document his treatment rationale for starting leuprolide in April 2011.

Patient G

82. Patient G, then a nine year-old female residing in residing in a state other than Maryland, was initially assessed by Dr. Geier in 2009. Dr. Geier noted that Patient G had been previously diagnosed with ADHD and an auditory processing disorder.

83. On April 1, 2010, Dr. Geier prescribed leuprolide 0.7 ml SQ daily to Patient G.

84. On April 12, 2011, the Respondent prescribed leuprolide 0.7 mg SQ daily to Patient G.

85. On April 26, 2011, the Respondent tripled Patient G's dosage of leuprolide, prescribing 2.1 mg SQ daily.

86. The Respondent failed to document his treatment rationale for prescribing leuprolide to Patient G. The Respondent failed to document why he tripled her dosage two weeks later. Patient G's chart does not contain any note written by

[15] At Dr. Geier's hearing on the Board's charges, his chelation expert testified that coproprophyrin levels are an indicator of the presence of mercury or lead in the body.
[16] David is the name of Dr.Geier's unlicensed son who worked in the Respondent and Dr. Geier's office.

the Respondent that he had any contact with Patient G or her parents in April 2011.

87. In his summary of care, the Respondent failed to discuss the April 2011 prescriptions.

Patient H

88. Patient H, then a six-year-old female residing in residing in a state other than Maryland, was initially assessed by an associate of Dr. Geier in July 2009. Patient H's past diagnosis was noted as: "hot temper." Patient H had not previously been diagnosed with either autism or PDD-NOS.

89. On June 1, 2010, Dr. Geier started leuprolide 0.4 ml SQ daily for Patient H.

90. On April 18, 2011, the Respondent prescribed 0.7 ml leuprolide SQ daily to Patient H.

91. On April 26, 2011, the Respondent tripled Patient H's dosage of leuprolide to 2.1 mg SQ daily.

92. The Respondent failed to document his treatment rationale for prescribing leuprolide to Patient H. The Respondent failed to document why he tripled her dosage two weeks later. Patient H's chart does not contain any note written by the Respondent that he had any contact with Patient H or her parents in April 2011.

93. When interviewed by Board staff, the Respondent stated that he did not review Patient H's laboratory studies before tripling her dosage of leuprolide.

Patient I

94. Patient I, then a 14- year-old male residing in residing in a state other than Maryland, was initially interviewed in March 2011 by an individual identified by the Respondent as the office manager of a Genetic Consultants' office in the state in which Patient I resides. Patient I was noted to have been diagnosed with Asperger Disorder when he was six years old.

95. On January 21, 2011, prior to Patient I's initial evaluation, Dr. Geier prescribed leuprolide 0.8 ml SQ daily to Patient I.

96. On April 8, 2011, the Respondent wrote a prescription continuing Patient I's leuprolide dosage.

97. On May 6, 2011, the Respondent tripled Patient I's dosage of leuprolide, prescribing 2.4 ml SQ daily.

98. The Respondent failed to document his treatment rationale continuing Patient I's leuprolide as prescribed by Dr. Geier in April 2011 or for tripling Patient I's dosage less than 30 days later.

99. Patient I's chart does not contain any documentation that the Respondent had contact with Patient I or his family between April 8, 2011 and May 6, 2011.

100. When questioned by Board staff why he tripled the dosage, the Respondent stated that he "was probably just following Dr. Geier's recommendation." The Respondent further stated that he did not know what circumstances would have warranted tripling Patient J's dosage in less than 30 days.

101. The Respondent's actions, as set forth above, constitute a substantial likelihood of risk of serious harm to the public health, welfare and safety which imperatively

requires the immediate suspension of his license to practice medicine under Md. State Gov't Code Ann. § 10-226(c)(2)(i) and Code Md. Regs. tit. 10, § 32.02.05B(7).

CONCLUSION OF LAW

Based on the foregoing facts, the Board concludes that the public health, safety or welfare imperatively require emergency action in this case, pursuant to Md. State Gov't Code Ann. § 10-226 (c)(2)(i) (2009 Repl. Vol.).

ORDER

Based on the foregoing, it is this 13th day of February, 2013, by a majority of the quorum of the Board:

ORDERED that pursuant to the authority vested by Md. State Gov't Code Ann., § 10-226(c)(2), the Respondent's license to practice medicine in the State of Maryland be and is hereby **SUMMARILY SUSPENDED**; and be it further

ORDERED that a post-deprivation hearing in accordance with Code Md. Regs. tit. 10, § 32.02.05.B(7) and E on the Summary Suspension has been scheduled for **Wednesday, February 27, 2013, at 1:00 p.m.,** at the Maryland Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215-0095; and be it further

ORDERED that at the conclusion of the **SUMMARY SUSPENSION** hearing held before the Board, the Respondent, if dissatisfied with the result of the hearing, may request within ten (10) days an evidentiary hearing, such hearing to be held within thirty (30) days of the request, before an Administrative Law Judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031-1301; and be it further

ORDERED that on presentation of this Order, the Respondent **SHALL SURRENDER** to the Board's Compliance Analyst, the following items:

(1) the Respondent's original Maryland License;

(2) the Respondent's current renewal certificate;

(3) the Respondent's Maryland Controlled Dangerous Substance Registration;

(4) all controlled dangerous substances in the Respondent's possession and/or practice;

(5) all Medical Assistance prescription forms;

(6) all prescription forms and pads in his possession and/or practice; and

(7) Any and all prescription pads on which his name and DEA number are imprinted; and be it further

ORDERED that during the period of Summary Suspension, in accordance with Title 4, subtitle 3 of the Health-General article, the Respondent shall have a continuing duty, on proper request, to provide details of a patient's medical record to the patient, another physician or hospital; and it is further

ORDERED that a copy of this Order of Summary Suspension shall be filed with the Board in accordance with Md. Health Occ. Code Ann. § 14-407 (2009 Repl. Vol.,); and be it further

ORDERED that this is a Final Order of the Board and, as such, is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 *et seq.*

Andrea L. Mathias, M.D., M.P.H.
Chair
Maryland State Board of Physicians