IN THE MATTER OF	*	BEFORE THE
RYAN GREYTAK, M.D.	*	MARYLAND STATE
	*	BOARD OF PHYSICIANS
APPLICANT	*	Case Number: 2013-0562

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

FINAL DECISION AND ORDER

On January 20, 2012, Ryan Greytak, M.D. applied for an initial medical license with the Maryland State Board of Physicians (the "Board"). On June 12, 2014, the Board issued a Notice of Intent to Deny Application for Initial Medical Licensure. The Board may "deny a license to an applicant . . . for any of the reasons that are grounds for action under § 14-404 of this title." Md. Code Ann., Health Occ. § 14-205(b)(1)(iii)[1] (2014 Repl. Vol.). The Board based its intent to deny on Dr. Greytak's unprofessional conduct in the practice of medicine, Health Occ. § 14-404(a)(3)(ii), and for lack of "good moral character," Health Occ. § 14-307(b) (2014 Repl. Vol.). Dr. Greytak requested a hearing.

After a two day evidentiary hearing in January 2015, at the Office of Administrative Hearings ("OAH"), on April 3, 2015, the Administrative Law Judge ("ALJ") issued a proposed decision recommending the denial of Dr. Greytak's application. The ALJ concluded that Dr. Greytak engaged in unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii), authorizing the Board to deny his application. *See* Health Occ. § 14-205(b)(1)(iii). The ALJ also concluded that Dr. Greytak's application for licensure should be denied based upon his lack of good moral character. Health Occ. § 14-307(b). Dr. Greytak filed exceptions, and the Board held a hearing on his exceptions on June 24, 2015.

[1] The notice cited Health Occ. § 14-205(a)(1)(iii), which was moved to § 14-205(b)(1)(iii) in 2009. For simplicity, this decision will only refer to Health Occ. § 14-205(b)(1)(iii).

FINDINGS OF FACT

The Board adopts the ALJ's Proposed Findings of Fact and Discussion. The ALJ's Proposed Findings of Fact and Discussion (pages 4-46) are incorporated by reference into the body of this document as if set forth in full. *See* attached ALJ Proposed Decision, Exhibit 1. The factual findings were proven by a preponderance of the evidence.

To summarize, Dr. Greytak was a medical resident in psychiatry from July 2010 until June 2013 at a hospital in Maryland. While a resident at the hospital, Dr. Greytak made numerous sexual comments to and inappropriately touched a co-resident ("Resident A"). Dr. Greytak also sent inappropriate sexual messages on the residency paging system to Resident A. While in the hospital, Dr. Greytak rubbed against Resident A and tried to touch her breasts. Additionally, Dr. Greytak went into Resident A's office at the hospital to discuss sexual topics, such as asking if they could be "friends with benefits." In one instance, Dr. Greytak told Resident A that he had an erection and asked if she could help him with it. Further, he then rubbed against her. He touched Resident A's abdomen while commenting about her appearance in front of a faculty member. Even more, when upset with Resident A for hospital related tasks, Dr. Greytak texted her, calling her a "dirty bitch" and "nasty whore." Dr. Greytak's inappropriate comments and acts occurred about two times a week over a period of months.

In addition to the incidents at the hospital, while at a bar with other residents, Dr. Greytak pushed Resident A into a janitor's closet in an attempt to engage in sexual activity with her, but she pushed him off of her.

Dr. Greytak made further inappropriate comments with sexual innuendo and other rude comments to others besides Resident A during his residency program. Dr. Greytak was irate, profane, and inappropriate while talking to a supervisor after being taken off a rotation in the

Psychiatric Emergency Department due to concerns with his handling of patients. He questioned the supervisor's character, professionalism, medical competence, and intelligence. He again berated the supervisor after she gave him a poor review.

Dr. Greytak was placed on probation on August 1, 2012, by his residency program based on an investigation by the hospital's Office on Institutional Equity. The probationary conditions required Dr. Greytak to focus on treating members of faculty and staff in a respectful, courteous, and dignified manner.

In his initial application to the Board on January 20, 2012, Dr. Greytak answered "no" to the following questions:

c. Has any licensing or disciplinary board (including Maryland), or a comparable body in the armed services, filed any complaints or charges against you or investigated you for any reason?

e. Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?

f. Has a hospital, related health care facility, HMO, or alternative health care system denied your application for, or failed to renew your privileges; or limited restricted, suspended or revoked your privileges in any way?

On August 15, 2012, Dr. Greytak spoke with a staff member of the Board and told her that the hospital placed him on probation. The staff member instructed him to submit a signed, dated, written statement about the probation and to revise his application answers. Dr. Greytak did not immediately revise his answers and was, thus, contacted by the Board on March 27, 2013. The Board reiterated its request for the revisions. Dr. Greytak submitted changes on April 11, 2013. He described the conditions of his probation, along with a statement explaining that, as of April 9, 2013, he was no longer on probation. The letter, however, did not specify the reasons he had been placed on probation, as the Board had requested.

ANALYSIS

Under Health Occ. § 14-205(b)(1)(iii), the Board may "deny a license to an applicant . . . for any of the reasons that are grounds for action under § 14-404 of this title." The underlying ground under §14-404 in the Board's notice of intent to deny was Health Occ. 14-404(a)(3)(ii) "[u]nprofessional conduct in the practice of medicine." Additionally, the notice of intent to deny was based on Health Occ. § 14-307(b), which requires the applicant to possess "good moral character."

A. Sexual Misconduct and Rude Behavior

Unprofessional conduct is "conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession." *Salerian v. Maryland State Board of Physicians* 176 Md. App. 231, 248 (2007) (citing *Finucan v. Maryland Board of Physician Quality Assurance*, 380 Md. 577, 593 (2004)). Sexual harassing conduct at a hospital is unprofessional conduct in the practice of medicine. *Board of Physician Quality Assurance v. Banks*, 354 Md. 59, 62-63 (1999). Dr. Banks acted immorally or unprofessionally in the practice of medicine by touching, rubbing, and pinching hospital employees as well as making inappropriate comments regarding sex and requesting sexual relationships with the hospital employees. *Id.*

The Board finds that Dr. Greytak acted unprofessionally in the practice of medicine. Like Dr. Banks, Dr. Greytak engaged in inappropriate sexual touching and inappropriate sexual comments to Resident A at the hospital. During his residency, Dr. Greytak's rude behavior to supervisors and his sexual jokes and innuendo to coworkers were unprofessional.

Dr. Greytak admits that his behavior was unprofessional. At his exceptions hearing, Dr. Greytak stated, "I take responsibility for the things that I have done. I have said and done

terrible things that are unprofessional that I should not have said and I should not have done. It is not becoming of a physician. It is not a good representation of what a physician should be, especially a psychiatrist." The Board agrees. Dr. Greytak's conduct was unprofessional, warranting the denial of his application for a medical license under § 14-205(b)(1)(iii).

Dr. Greytak's conduct while a resident also demonstrates that Dr. Greytak lacks the good moral character that is required for licensure. Dr. Greytak engaged in repeated unwanted sexual advances and sexually harassing behavior. His shoving Resident A into a broom closet to touch her in a sexual manner until she pushed him off is particularly troubling. This behavior demonstrates a lack of good moral character. *See* Health Occ. § 14-307(b).

B. Incomplete Application

False statements on a licensure application are also unprofessional conduct in the practice of medicine because such statements "impede[] the Board's ability to 'make informed decisions regarding physician qualifications and adequately safeguard the public health." *Kim. v. Maryland State Bd. of Physicians*, 423 Md. 523, 539 (2011); *see also Cornfeld v. State Board of Physicians*, 174 Md. App. 456, 479 (2007) (false statements to a hospital investigatory body is unprofessional conduct in the practice of medicine).

Dr. Greytak failed to update his application to include information regarding the probation imposed by his residency program. The ALJ viewed his omission of an outline of what happened as "glaring." The ALJ concluded that Dr. Greytak was attempting to conceal information by failing to provide information when it was requested. The Board concurs that his willful disregard of his obligation to update his application and provide a written statement of affirmative answers after being instructed to do so reflects behavior similar to conduct that has been deemed unprofessional. *See* Health Occ. § 14-205(b)(1)(iii).

Additionally, in the context of applying to the Maryland Bar, the Court of Appeals held that "good moral character includes truthfulness and candor, and absolute candor is a requisite of admission." *In re Application of Cramer*, 427 Md. 612, 622 (2012) (*per curiam*). Dr. Greytak did not update his application with the Board after he was placed on formal probation, at least eight months later. Board staff specifically told him that he needed to update his application. He only changed his application after the probation had ended, and, did not describe the conduct for which he was placed on probation. As the ALJ explained, the timing of his actions demonstrate a lack of candor and an attempt to manipulate the Board process. Dr. Greytak's prompt updates to the Board for positive information and his significant delays in presenting new negative information and general lack of candor demonstrate that he lacks good moral character, requiring the denial of his license under § 14-307(b) of the Health Occupations Article.

EXCEPTIONS

Dr. Greytak filed a letter, dated April 22, 2015, which the Board considers his exceptions to the proposed denial of his medical license. Dr. Greytak argued that he "ha[s] substantially reformed [him]self, in terms of professionalism and moral/ethical conduct" in the years since the incidents at issue in the notice of intent to deny.

Dr. Greytak does not challenge the specific incidents of unprofessional conduct found by the ALJ. Because Dr. Greytak does not challenge the ALJ's proposed finding of unprofessional conduct and because Dr. Greytak admits that he has "said and done terrible things that are unprofessional," there is no dispute that the Board may deny Dr. Greytak's application under Health Occ. § 14-205(b)(1)(iii).

On exceptions, concerning the ALJ's finding that he failed to meet the good moral character requirements, Health Occ. § 14-307(b), Dr. Greytak sought to introduce several

additional documents that were not submitted into evidence before the ALJ. Specifically, Dr. Greytak's written exceptions discuss (1) a letter detailing his good performance during his fellowship in geriatric psychiatry at the University of California San Diego; (2) letters from physicians in his group evaluating his performance during his fellowship; (3) a performance evaluation during his employment at the San Diego County Psychiatric Hospital; (4) a copy of a December 2014 report sent to the Medical Board of California; (5) a copy of the Medical Director's justification for terminating him and revoking his privileges; (6) evaluations from coworkers and letters from physicians at Senior Medical Associates, where he began working in 2015. Despite the reference to these documents in his exceptions, the Board only received (1) the letter regarding his fellowship, (6) evaluations and letters from other employees and physicians at Senior Medical Associates, and one unsigned and undated letter directed to a hospital credentialing committee from a registered nurse (which was not referenced in his exceptions letter). The remaining documents listed by Dr. Greytak were not provided to the Board.

The evidence Dr. Greytak cites here was not presented to the ALJ. According to the Board's regulations, "[t]he exceptions hearing is based upon [the] evidentiary record established before the Office of Administrative Hearings." COMAR 10.32.02.11C(9). The Board is cognizant of *Mehrling v. Nationwide Ins. Co.*, 371 Md. 40, 62 (2002), which held that "filing exceptions is the only appropriate method for a party to present post-hearing evidence for an agency's possible consideration." However, *Mehrling* notes that in that case "there is nothing in the statute *or corresponding regulations* that would preclude a party from offering new evidence in support of the party's exceptions . . . before such evidence may be admitted." *Id.* at 61 (emphasis added). Here, in contrast, the regulations specifically restrict the exceptions hearing to

the evidentiary record established at OAH. The entirety of the new evidence Dr. Greytak seeks to introduce is not admitted and has not been considered by the Board. COMAR 10.32.02.11C(9).

Moreover, even if *Mehrling* permitted the Board to accept new evidence, Dr. Greytak does not explain why much of this newly produced evidence was not previously submitted to the ALJ. Only evaluations from his coworkers at Senior Medical Associates could not have been presented at the OAH hearing in January 2015.

The Board will also not accept Dr. Greytak's new evidence because it is incomplete. The State indicated in its reply to the exceptions that Dr. Greytak failed to present significant information about the termination of his employment and his loss of privileges at the San Diego County Psychiatric Hospital. The Board is reluctant to admit new evidence about Dr. Greytak's moral character without being able to consider the specifics of the alarming incidents after he left his residency, including the termination of his employment and the loss of hospital privileges. The admission of the documents Dr. Greytak seeks to introduce would require a new full-scale evidentiary hearing, precisely what the Board's regulations intend to prohibit.

Finally, even if the Board were considering Dr. Greytak's submitted documents, the Board concludes that it would be insufficient to override the evidence presented to the ALJ. The Board received only letters from Dr. Sewell at UC San Diego and from Dr. Greytak's colleagues at Senior Medical Associates. Dr. Greytak's performance reviews by Senior Medical Associates employees, however, were not official reports or created or mandated by Senior Medical Associates itself, but, are on evaluation forms created by Dr. Greytak. While these reviews state their satisfaction with Dr. Greytak, the reviews are brief, include little detail about his character, and cover a short period, from January 25 to April in 2015. The positive reviews and letters

created and solicited by Dr. Greytak are encouraging. However, the section a letter from Dr. Cann, Medical Director of San Diego County Psychiatric Hospital, that was read by the administrative prosecutor (with Dr. Greytak's permission) during the exceptions hearing as rebuttal to the documents presented by Dr. Greytak paint a different picture of his employment after residency. The letter, as presented at the hearing, states, "Dr. Greytak began to be involved in a series of confrontations with various members of hospital staff. . . . [and Dr. Greytak] made sexually belittling remarks to a social worker in front of others at the nursing station." In his exceptions letter, Dr. Greytak failed to mention the various confrontations or the sexually belittling comments as reasons for his dismissal.

CONCLUSIONS OF LAW

Based upon the findings of fact, the Board concludes that Dr. Greytak is guilty of unprofessional conduct in the practice of medicine in violation of § 14-404(a)(3)(ii) of the Health Occupations Article, thus, on this ground, pursuant to Health Occ. § 14-205(b)(1)(iii), the Board denies Dr. Graytak's application for a license. Also, based on the findings of fact, the Board concludes that Dr. Graytak does not possess good moral character as required for licensure under Health Occ. § 14-307(b). Thus, the Board also denies Dr. Greytak's application for his failure to meet the good moral character requirement for licensure.

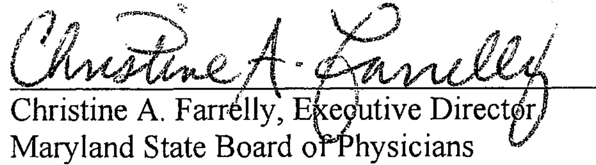
ORDER

It is, by an affirmative vote of a majority of the quorum of the Board, hereby

ORDERED that the application of Ryan Greytak, M.D. for a license to practice medicine in Maryland is **DENIED**; and it is further

ORDERED that this is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. § 4-101 *et seq.*

8/21/2015
Date



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(a), Dr. Greytak has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within 30 days from the date of mailing of this Final Decision and Order. The cover letter accompanying this final decision and order indicates the date the decision is 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. Greytak 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 S. Finkler
Assistant Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

MARYLAND STATE BOARD OF PHYSICIANS	* BEFORE KIMBERLY A. FARRELL,
v.	* AN ADMINISTRATIVE LAW JUDGE
RYAN GREYTAK, M.D.,	* OF THE MARYLAND OFFICE
APPLICANT	* OF ADMINISTRATIVE HEARINGS
Applicant for License	* OAH No.: DHMH-MBP-70-14-37633
	* BOARD CASE No.: 2013-0562

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PROPOSED DECISION

STATEMENT OF THE CASE
ISSUES
SUMMARY OF THE EVIDENCE
PROPOSED FINDINGS OF FACT
DISCUSSION
PROPOSED CONCLUSIONS OF LAW
PROPOSED DISPOSITION

STATEMENT OF THE CASE

On January 20, 2012, Ryan Greytak, M.D., (Applicant)[1] filed an application for initial medical licensure (Application) with the Maryland State Board of Physicians (Board). On or about June 12, 2014, the Board issued a Notice of Intent to Deny Application for Initial Medical Licensure. Md. Code Ann., Health Occ. (HO) § 14-101 – 14-406 (2014).[2] The Applicant requested a hearing challenging the Board's action. The Board transmitted this matter to the Office of Administrative Hearings (OAH) on October 21, 2014. I held a telephone scheduling conference on November 10, 2014; there was no need for a prehearing conference.

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[1] The Applicant is licensed to practice medicine in California.

[2] Further references to the Health Occupations Article will be abbreviated as HO. When the Board issued its notice to the Applicant, it referred to the HO 2009 volume and the 2013 Supplement. References in this decision are to the 2014 volume. Section 14-205 has been amended, as discussed below; however, the amendment does not affect the substance of this case.

I held a hearing on the merits on January 20 and 21, 2015. The hearing was held at OAH offices located at 11101 Gilroy Road, Hunt Valley, Maryland. Md. Code Ann., Health Occ. § 14-405 (2014). Thomas Morrow, Esquire, represented the Applicant; Assistant Attorney General Christopher Anderson, Administrative Prosecutor, represented the State. I closed the record on February 6, 2015, after receipt of the parties' post-hearing briefs.

The contested case provisions of the Administrative Procedure Act, the Rules of Procedure for the Board, and the Rules of Procedure of the OAH govern procedure in this case. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2014); Code of Maryland Regulations (COMAR) 10.32.02; COMAR 28.02.01.

ISSUES

- Is the Applicant guilty of unprofessional conduct in the practice of medicine in violation of HO section 14-404(a)(3)(ii)?
- Does the Applicant lack the good moral character required for licensure to practice medicine by HO section 14-307(b)?
- Did the Board properly deny the Applicant's application for initial medical licensure?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following exhibits into evidence on behalf of the Board:[3]

1. Board Report of Investigation, 9/9/13;
2. Board Subpoena duces tecum (SDT) for the Respondent's residency file, 10/3/12;

[3] At my request the Board emailed a copy of the exhibit list to me to be reproduced in this proposed decision. The Board uses the term "Respondent" where this proposed decision uses the term "Applicant." I did not edit the Board's exhibit list. Board exhibit 26, which was marked for identification but not admitted into evidence, was not part of the original exhibit book, and did not appear on the Board's index. That exhibit is located in the exhibit binder's interior pocket. The Board's exhibit book is Bates numbered. References to Board exhibits will be to the Bates numbered page(s).

3. The Respondent's residency file, 10/19/12;

4. Materials from Board Licensure Unit, including application of the Respondent, 2/5/13;

5. Board Correspondence to the Respondent regarding opening an investigation, 3/27/13;

6. Fax to Board from the Respondent, including revised application page 9, 4/11/13;

7. Fax to Board from the Respondent, including written response, 4/11/13;

8. Fax to Board from the Respondent, including letter terminating his probation, 4/25/13;

9. Board Subpoena ad testificandum (SAT) and blank release form to the Respondent 5/14/13;

10. Release forms signed by the Respondent, 5/28/13;

11. Transcript of Board Interview with the Respondent, 5/28/13;

12. Board SDTs to the Respondent's mental health providers, 6/12/13;

13. File from the Respondent's Psychologist, 6/25/13;

14. Fax and email printouts of the Respondent's California medical license, 7/9/13;

15. The Respondent's mental health records received by email from [redacted] responsive to Board SDT, 7/31/13;

16. The Respondent's mental health records received by regular mail from [redacted] responsive to Board SDT, 8/5/13;

17. Board SDT to California medical board, 8/21/13;

18. Documents, including California medical application received from Respondent at verbal request of Board investigator, 8/29/13;

19. Board SDT requesting the Respondent's [redacted] Corporate Security file, 8/29/13;

20. Documents received from the Respondent's residency director, 9/3/13;

21. Documents received from California medical board responsive to Board SDT, 9/9/13;

22. Documents received from [redacted] Corporate Security responsive to Board SDT, 9/17/13;

23. Affidavits of witnesses interviewed by [redacted] Office of Institutional Equity;

24. Printouts of apologies made on Facebook by the Respondent;

25. Notice of Intent to Deny the Respondent's Application for Initial Licensure and Cover letter, 6/12/14.

26. Not admitted

The Applicant did not offer any exhibits as evidence.[4]

Testimony

The following witnesses testified on behalf of the Board:

- [redacted], Assistant Vice-Provost and Title 9 Coordinator for [redacted]
- [redacted], PhD, psychologist
- [redacted], M.D., psychiatrist

The Applicant testified on his own behalf, and presented the following witnesses:

- [redacted] M.D., Associate Professor of Psychiatry, [redacted]
- [redacted], psychiatric therapist, [redacted]

Neither side offered or qualified any witness as an expert.

PROPOSED FINDINGS OF FACT

I find the following facts by a preponderance of the evidence:

Background information on the Applicant

1. The Applicant is a 2005 summa cum laude graduate of the University of Florida with a degree in Chemistry.

[4] The Applicant provided a small number of pages from the Board exhibit as an extract of sorts, to highlight certain information and make it easier to reference quickly, but the materials were not marked as additional exhibits.

2. He attended medical school at the University of Pittsburgh, graduating in 2009. He then began a one-year internship[5] in internal medicine at Allegheny General Hospital in Pittsburgh, Pennsylvania.

3. As that internship drew to a close, the Applicant decided that he wanted to pursue additional residency training in psychiatry. He applied to and was accepted at [redacted] for a three-year term as a resident in psychiatry, beginning July 2010.

4. As a teenager the Applicant was diagnosed with attention deficit hyperactivity disorder (ADHD). While in medical school the Applicant saw a psychiatrist who confirmed the ADHD diagnosis and also diagnosed obsessive compulsive disorder (OCD).

5. The Applicant is highly intelligent.

6. The Applicant has difficulty in reading people. In both personal and professional relationships he tends to be "oblivious to nonverbal cues or situational realities."[6] Board 571; Transcript (T) 262.[7]

7. The Applicant was married, but he and his wife separated in November 2010.

8. When the Applicant and his wife separated, the Applicant began drinking alcohol to a degree that was, as the Applicant phrased it, "excessive and problematic." This lasted approximately from November 2010 until February or March 2011. T 247.

9. The Applicant successfully completed his [redacted] residency in June 2013.

10. After his [redacted] residency, the Applicant secured a Fellowship in California in Gerontology at the University of California at San Diego.

[5] In the records and testimony the Applicant's internship is sometimes described as PGY1 (post graduate year 1). The years of residency at [redacted] are sometimes designated as PGY 2, PGY 3, etc.
[6] The quoted language is from Board Tab 13, Report of Neuropsychological Evaluation, Bates numbered page 571.
[7] For the Record provided a courtesy copy of the transcript of testimony in this matter. References to the transcript and its page numbers will be noted as "T" followed by the corresponding page number.

11. The Applicant was licensed to practice medicine in the State of California as of July 6, 2013.

12. The Applicant is board certified in general psychiatry and geriatric psychiatry.

Interaction with Dr. [redacted]

13. The Applicant met [redacted] in early July 2010. She was a fellow resident at [redacted] and became a friend.

14. Dr. [redacted] attended social events with the Applicant and his wife and when Dr. [redacted] had knee surgery sometime around August 2010, she and the Applicant were on the same unit, so the Applicant helped Dr. [redacted] by doing such things as bringing her documents or binders or by wheeling patients to her office for appointments.

15. Beginning sometime after July 1, 2010 and continuing into 2011,[8] the Applicant would go to Dr. [redacted]'s office at [redacted] and make sexually loaded comments or engage in sexual behaviors a couple of times each week. Examples include walking into her office and rubbing or trying to touch her breasts. [redacted] would push the Applicant away or tell him to stop and get out of her office.

16. In July 2010 the Applicant sent an email to Dr. [redacted] and at least two other female doctors in the residency program. The email read, "you HAVE to watch this! :) This is probably the most ACCURATE musical portrayal of what ACTUALLY HAPPENS at the hospital when patients come to see us in the PSYCH department..." Board 331 (ending ellipse in original). What followed was a link to a YouTube video showing people purporting to be doctors and residents dancing provocatively while singing a song about men having their testicles examined.

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[8] For some findings of fact, dates are hazy because witnesses no longer remember the date or because the evidence suggested conflicting dates or date ranges or did not mention any particular date. I have used the best approximation of dates I could glean from the evidence.

17. In August 2010 the Applicant and Dr. [redacted] went to a bar with other [redacted] residents. While there, Dr. [redacted] went to the restroom which was in the back of the bar, away from their table. The Applicant followed Dr. [redacted], pushed her into a janitor's closet, and tried to engage in sexual contact with her. Dr. [redacted] was able to push him off and escape the closet; however, she was very upset by the incident and told a colleague about it at the time.

18. In September 2010 Dr. [redacted] was attacked by an ex-boyfriend.[9]

19. As a result, Dr. [redacted] suffered post traumatic stress symptoms. She had to see a psychiatrist. She became very anxious and had to take medications for anxiety and depression. The medications sedated her and affected cognitive function and memory. She had to discuss her personal situation with her residency program directors, Drs. [redacted] and [redacted] because her performance was affected. She did not want to draw any further negative attention to herself having just started her residency.

20. The Applicant used a [redacted] internal paging system intended for business-related messages to anonymously send inappropriate messages to Dr. [redacted], including multiple messages stating that she was "hot." T 268-269. The Applicant later acknowledged that he sent the pages.

21. Around the time the Applicant and his wife separated, roughly November 2010, and for a few months thereafter, through February or early March 2011, the Applicant came to believe that he and Dr. [redacted] were romantically involved.

[9] The Applicant's understanding was that the attacker had tried to kill Dr. [redacted] and that he had been charged with attempted murder. T 249.

22. Dr. [redacted] did not have any romantic interest in the Applicant, however, in December 2010 or January 2011, the Applicant and Dr. [redacted] engaged in sexual intercourse. Both of them had been drinking immediately prior to the encounter.

23. The Applicant's recollection of the event is that Dr. [redacted] was an active participant who took the lead and enjoyed the physical intimacy.

24. Dr. [redacted]'s recollection of the event is that she was sickened from the alcohol, laid down, and awoke to find the Applicant engaging in non-consensual intercourse with her which caused her to crawl across the floor trying to get away from him.

25. The two remained friends for a period of weeks or months, but their friendship cooled after that, and they had much less contact with each other. Around July 2011 the Applicant started coming into Dr. [redacted]'s office making sexual comments such as saying that he had an erection and asking Dr. [redacted] if there was anything she could do about it, trying to rub himself against Dr [redacted] or the chair she was sitting in in connection with remarks about having an erection, or asking if they could be "friends with benefits," meaning that he wanted to engage in sexual activity with her. When this occurred, Dr. [redacted] told the Applicant to leave her office and tried to ignore him. Sometimes he left immediately, but sometimes he would stay despite her telling him to leave.

26. Sometime between July and December 2011, Dr. [redacted] was with a group in the residency program including Dr. [redacted] a faculty member. The Applicant walked past Dr. [redacted] and then reached back and trailed his hand across Dr. [redacted]'s abdomen making a comment in the nature of, "You're looking good." Board 330. Dr. [redacted] was taken aback, finding the contact inappropriate, and made a remark to the effect of, "What the hell was that?" T 130. Dr. [redacted] was uncomfortable, but downplayed the incident.

27. On one occasion Dr. [redacted] asked the Applicant to close the door while he was conducting an interview of a patient, so as not to disturb others around him. The Applicant became irate and engaged in a loud and angry outburst rebuking Dr. [redacted]. The patient in the Applicant's office had claustrophobia, panic disorder, or some other condition which led her to ask the Applicant to keep the door open during their meeting.

28. In November 2011, Dr. [redacted] texted the Applicant about being late to relieve her at work. The Applicant was very frequently late for work assignments. In response, the Applicant sent a text message to Dr. [redacted] calling her a "dirty bitch" and a "nasty whore." Dr. [redacted] in turn called the Applicant a "sociopath." T.163, 204; Board 327.

29. At one point, an outside lecturer came to address a group which included residents. Dr. [redacted] believed that the Applicant had asked too many questions and kept others from having a fair chance to engage with the speaker. Dr. [redacted] asked something like, "Are you going to follow him home, too?" The Applicant misconstrued this as a remark intended to convey that he was homosexual and that his interest in the speaker was personal rather than professional.

30. In a discussion of transgender or cross-dressing patients, the Applicant asked the professor emeritus conducting the training how he would feel if he had to dress in women's clothes and come to work every day. The question, intended as an attempt at humor, was disruptive and out of context. Dr. [redacted] asked the Applicant how his remark was pertinent to the discussion. The Applicant became very angry and stormed out of the room. The Applicant left the clinic even though he had a patient he had been assigned to evaluate. His work had to be assigned to other residents.

31. By late fall and early winter 2011, the Applicant believed that Dr. [redacted] was treating him differently than she had before, that she was challenging him in public during activities related to residency and that she was critical of him in clinical and educational settings.

32. On November 30, 2011, the Applicant filed with the [redacted] Office of Institutional Equity (OIE) a sexual harassment complaint against Dr. [redacted], alleging that over the past five or so months she had made a series of offensive remarks about him, some sexual some non-sexual, in front of others in the residency setting.

33. On December 1, 2011, the Applicant sent an email to Dr. [redacted] itled, "Agreement." It read in part:

> I am not trying to get you in any trouble or get back at you. I just want you to stop making demeaning, insulting and disrespectful comments to me. Everyone deserves to be treated by others with the utmost respect. I apologize to you for the things I have said to you in the past that were hurtful and disrespectful, and I openly acknowledge that I have been disrespectful to you on numerous occasions in the past. I have made a concerted effort to be as respectful and professional as possible in regards to you over the past few weeks.

Board 326, 330.

34. Between roughly January 2012 and the end of the residency program, the Applicant and Dr. [redacted] had only minimal contact when their schedules made it unavoidable. [redacted] actively tried to schedule so as to keep contact between them to a minimum.

35. After graduation through September 28, 2014, they had no contact whatsoever.

36. On September 28, 2014, at 10:43 p.m., the Applicant sent a message to Dr. [redacted] via Facebook:

> Hi [redacted], I just wanted to say I am very sorry for mistreating you in the past. I am certainly a flawed person. I have realized this about myself, and I am working hard to change and improve myself, and never to poorly treat others as I treated you in the past.

I hope that you are doing well and that you are happy.

Sincerely,
Ryan

Board 1047.

37. He followed that up in November or December 2014 with additional messages: "[redacted] can we please talk?"; "I am so sorry for what I have done to you in the past. I don't know what to do now"; "please talk to me"; and a Facebook friend request. Board 1047-1049.

38. Dr. [redacted] did not respond to any of these attempts at contact.

The Applicant's contact with Dr. [redacted]

39. Dr. [redacted] met the Applicant while they were both residents in Pittsburgh. The Applicant emailed Dr. [redacted] telling her, "You would look hot naked." Dr. [redacted] also heard the Applicant insert sexually-related material into numerous discussions, even when completely irrelevant to the topic. Dr. [redacted] told the Applicant that his sexual comments were inappropriate and that he needed to stop. Board 965-966.

40. Dr. [redacted] felt the Applicant was helpful to her when she applied for a position at [redacted].

41. At [redacted] the Applicant commented to Dr. [redacted] upon noticing that she had cut her hair short, "You probably like women now." Board 966.

Some of the Applicant's interactions with others in professional settings

42. During his residency at [redacted] the Applicant often times spoke out of turn, very often inserting sexual innuendo and other inappropriate comments or attempts at humor into conversations in hospital settings. He generally failed to anticipate how others would react to his remarks. He also treated others rudely or was overly familiar or became angry with them inappropriately. Some of the Applicant's behaviors included:

- frequently addressing Dr. [redacted] the Director for Residency Education rudely, including an episode of cursing at him;[10]

- frequently addressing Dr. [redacted] the Associate Director for Residency Education rudely;

- approaching a fellow resident whom he knew casually from behind when she was pregnant, putting his arms around her, and resting his arms on her belly while inquiring about how the baby was doing;

- texting the same resident to meet him at the call room, where residents sleep, although there was no legitimate reason to do so;

- looking over the shoulders of fellow residents when they were on the computer and making a sexually charged comment about whatever he found on the screen no matter how innocuous it might be;

- disrupting an interview with a forensic patient by trying to inject "humor" related to whether the patient fed his diverse types of pets to each other and how a bleach allergy might affect his wardrobe choices;[11]

- injecting the facetious question, "So, do dentists rape people all the time?" during a serious discussion of legal distinctions between sex offenses and rape, where penetration was being highlighted (Board 372); and

- stating during a serious discussion of legal concepts surrounding sex with somebody who looks to be the age of consent but is not, "Then I'll have to check the ID next time." (Board 372.)

43. Female residents shut themselves in their offices on days when the Applicant was on the floor with them to avoid contact with him. When he was not there they would leave their office doors open.

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[10] The episode of cursing was referenced several times but the details are not contained in the record. In conducting direct examination, Counsel for the Applicant mentioned that, "I don't know what the exact comment was, it's never been elucidated but it's been referred to as your having cursed Dr. [redacted]" The Applicant testified that the cursing incident was, "[j]ust a horrible choice and a terrible way of interacting with a man I did truly respect and should not have spoken to in that way." T 267-268.

[11] The Applicant later wrote of this conduct and inappropriate comments made during his forensics rotation in an email addressed to his supervising physician, who declined to consider the Applicant as a candidate for a special program offered in forensics: "I wanted to ask you if there were any way that I could earn your endorsement after having done what I did during the forensic rotations. I realize that I said some very inappropriate things during our group discussion that rightly concerned you that I am not fit at [] time to begin a forensic fellowship program." Board 367. (Material in bracket missing due to a hole punch in the exhibit. Presumably the word is "this.")

44. After the Applicant made a complaint to OIE on November 30, 2011, OIE scheduled a meeting for the Applicant to come in to discuss his complaint. That meeting was set for December 6, 2011.

45. The morning of December 6, 2011, the OIE received an email from the Applicant advising that he did not think it would be a good idea to go through with the meeting, because he had been "informed" that he would be "retaliated against" if he pursued his complaint. OIE followed up by calling the Applicant, and, after a conversation, the Applicant agreed that OIE could follow up on the matter by contacting the leaders of his department.

46. Very shortly thereafter the Applicant advised OIE that he wanted to proceed with his complaint.

47. In addition to speaking with OIE, the Applicant complained to Drs. [redacted] and [redacted] about Dr. [redacted] in this general time frame. Drs. [redacted] and [redacted] called Dr. [redacted] in to discuss the Applicants allegations. When they heard Dr. [redacted]s version of events, they called OIE. As a result, a complaint was filed against the Applicant.

48. On December 27, 2011, OIE interviewed Dr. [redacted] Three days later Dr. [redacted] told OIE that she had filed rape charges against the Applicant for the incident occurring in late 2010 or early 2011.

49. The Applicant then declined to meet with OIE to discuss his complaint, at least in part concerned that criminal charges would be filed against him.

50. He eventually scheduled an appointment with OIE for February 14, 2012, at 12:00 p.m.

51. About fifteen minutes before the scheduled meeting, OIE employee [redacted] called the Applicant to say that the interviewer, [redacted] was running a little late. The Applicant advised that he was not coming to the interview and asked that he be interviewed by telephone instead. During the course of the phone call the Applicant believed that Ms. [redacted] treated him rudely. In response, the Applicant was personally insulting to Ms. [redacted] and began yelling. The Applicant's yelling was so loud that Ms. [redacted] had to hold the phone away from her ear. Ms. [redacted] asked the Applicant why he was yelling at her. Other OIE employees as far as ten feet away from Ms. [redacted] could hear the Applicant yelling through the phone saying, "I wasn't yelling." Board 347-348.

52. When the Applicant arrived for his interview with Ms. [redacted], she advised him that Ms. [redacted] would sit in to take notes. The Applicant stated that he was not comfortable with Ms. [redacted] being in the room. After speaking to the Applicant and Ms. [redacted] separately, Ms. [redacted] decided to reschedule the interview so that a different person could come take notes. The Applicant was very argumentative throughout the encounter, complaining that a second person should not be needed for an interview, that someone in his place should have been advised that a second person would sit in on the interview, that the meeting would have to be moved to [redacted][12] that the process was not moving fast enough (although he had previously refused to be interviewed), that he should be able to bring an attorney to the interview, and that Dr. [redacted] posed a threat to other men in the department.

53. During the encounter the Applicant glared at Ms. [redacted] and smirked at Ms. [redacted] both to such an extent that Ms. [redacted] asked him to stop. He demanded that Ms. [redacted] be replaced as the investigator. He was angry, loud, and hostile. His behavior was so concerning

[12] OIE's office was located at [redacted] [redacted] is located in another part of the city – [redacted] [redacted] It appears that the Applicant objected to having to travel away from the [redacted] area to be interviewed.

that when he left Ms. [redacted] locked the office's public entrance for about one-half hour to make sure that the Applicant could not re-enter. The person serving as OIE's Vice-Provost at the time could hear the Applicant yelling at Ms. [redacted] through the office walls and instructed Ms. [redacted] not to meet alone with the Applicant. Throughout the interview Ms. [redacted] was professional and made efforts to explain the process to the Applicant and to answer his questions.

54. Before leaving, the Applicant agreed to meet on Thursday, February 16, 2012, at 10:00 a.m. in [redacted] to conduct the interview.

55. On Wednesday, February 15, 2012, Ms. [redacted] emailed the Applicant to confirm the February 16 interview and to give the Applicant the location. She noted that the interview would include [redacted] Corporate Security Director of Investigations [redacted][13]

56. The Applicant emailed back that he would not meet with Ms. [redacted] and that he had to work at 10:00 a.m. Ms. [redacted] tried to get the Applicant to give her other dates and times when he could meet. He did not respond.

57. Officer [redacted] emailed the Applicant on February 16, 2012, seeking to reschedule.

58. The Applicant responded to Officer [redacted]'s email that same day:

> Hello Mr. [redacted],
> I am on vacation next week. I will not meet with [redacted] as during our meeting Tuesday she repeatedly displayed unbelievable bias in the favor of [redacted] [redacted] I raised concerns several times that [redacted] would be a risk to others at the hospital (i.e. she might accuse others of rape if they cross upset (sic) her) and [redacted] somehow "misinterpreted" over and over my statements to mean that somehow I was raising concerns about [redacted]s physical safety in the hospital.
>
> She also said that she doubted my credibility because I was upset that her secretary was quite rude over the phone with me.

[13] Portions of the OIE investigation were jointly conducted with the Corporate Security Office, which was also investigating the Applicant.

> If you want to proceed with this retaliatory investigation it will have to be done without [redacted]'s involvement.

Board 352.

59. Officer [redacted] emailed to ask for the opportunity to speak to the Applicant about refusing to be interviewed by Ms. [redacted]

60. The Applicant responded, still on February 16, 2012, "I would be happy to meet with you (and you alone) Monday Apr 27th at 4pm or Tues Apr 28 at 1pm." Board 352.

61. The Applicant eventually agreed to an interview which took place on May 5, 2012. The Applicant agreed to attend only after arrangements were made for Drs. [redacted] and [redacted] to sit in. Ms. [redacted] also participated in the interview.

62. By letter dated July 19, 2012, OIE advised the Applicant that it found his sexual harassment complaint to be unsubstantiated. OIE further advised that it found Dr. [redacted]'s allegation of non-consensual sex to be unsubstantiated,[14] but it found the allegations that he had shoved Dr. [redacted] into a closet in a bar and engaged in unwanted touching, that he had rubbed up against her and commented to her about an erection in the workplace, and that he had made offensive sexual comments to Dr. [redacted] and others in the workplace all to be substantiated.

63. In December 2014, after he learned that Ms. [redacted] was a potential witness against him in this proceeding, the Applicant called Ms. [redacted] and apologized for the way he conducted himself in 2012.

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[14] In the Applicant's closing memorandum he stated that, "[redacted] law enforcement authorities investigated the allegations of sexual assault [referring to the instance of intercourse] against Dr. [redacted] and found no probable cause upon which to take action against Dr. Greytak." The brief cites to Board 342, part of a Memorandum by [redacted]. Nowhere on Board 342 does it say that law enforcement authorities found a lack of probable cause as to Dr. [redacted] allegations. All that Board page 342 indicates is that the State's Attorney's Office declined to prosecute. That determination has nothing to do with a probable cause analysis as the State's Attorney must evaluate whether it can prove charges beyond a reasonable doubt.

The Applicant's interaction with Dr. [redacted][15]

64. The Applicant was assigned a rotation in the Psychiatric Emergency Department (PED) from January 1, 2012 to March 31, 2012.[16] He was supervised in that rotation by Dr. [redacted] the Director of Psychiatric Emergency Services.

65. Prior to the PED rotation, the Applicant had been directly supervised by Dr. [redacted] in a Community Psychiatry rotation. Dr. [redacted] completed an evaluation on the Applicant that was positive based on his performance in the Community Psychiatry rotation.[17]

66. During the PED rotation, the Applicant was taken off rotation due to concerns with his handling of certain patients in the Psychiatric Emergency Department. The Applicant called his supervisor, Dr. [redacted], on her cell phone to complain about being removed from rotation. He was irate, profane, and inappropriate.

67. The next day, Dr. [redacted] met with the Applicant and Dr. [redacted]. The Applicant questioned Dr. [redacted]'s character, her professionalism, her medical competence, and her intelligence. The Applicant was irate and inappropriate. He left slamming the door to the room.

68. Dr. [redacted] contacted the Applicant and told him he could not return to his rotation until he apologized to Dr. [redacted] and discussed with her certain ground rules for his treatment of patients.

69. The Applicant appeared for his next shift without speaking to Dr. [redacted]

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[15] Some references to this doctor use the name [redacted] and some use the name [redacted].
[16] Some records suggest the rotation was January through March, other suggest it was January and March (but perhaps not February).
[17] In an undated evaluation of his PED rotation with Dr. [redacted] the Applicant rated her as outstanding in the areas of availability and serving as a mentor for team leadership and rated her 4 out of 5 on serving as a mentor for patient care, quality of teaching, instruction and supervision, and overall experience with her. Board 409. In an undated evaluation of his Community Psychiatry rotation with Dr. [redacted] the Applicant rated her with very good and excellent ratings and added, "Dr. [redacted] was always energetic, engaging, and helpful when I discussed (and continue to discuss) patients with her. She has an excellent sense of that the key issues to be addressed in patient care are[.] Board 417.

70. Dr. [redacted] contacted the Applicant and reiterated the requirements for him to return to rotation.

71. The Applicant never apologized to Dr. [redacted]

72. The Applicant did discuss ground rules for treatment of patients with Dr. [redacted]

73. Dr. [redacted] completed an evaluation of the Applicant's rotation in the Psychiatric Emergency Department.

74. Ratings on the evaluation are on a scale or 1 to 5. 5 is "superior"; 4 is "very good"; 3 is "good"; 2 is "Fair (and acceptable)"; 1 is "unsatisfactory." A reviewer may also mark that a particular area is "NA" for not applicable. *See, e.g.,* Board 267.

75. Dr. [redacted] rated the Applicant with a 2 on several evaluation areas.

76. The Applicant strongly disagreed with this assessment and when he learned of the evaluation he called Dr. [redacted] on her cell phone as she was picking up her child from daycare. The Applicant wanted to discuss his evaluation right that moment. Dr. [redacted] told the Applicant that she would meet with him to discuss the evaluation but that the phone call was not the right time or place. The Applicant would not terminate the call and he again questioned Dr. [redacted]'s character and asserted that she had not spelled all words correctly in her evaluation. Dr. [redacted] hung up on the Applicant.

77. Due to the behavior of the Applicant, his tone, and the content of his call, Dr. [redacted] resolved not to meet alone with the Applicant in the future.

Efforts to assist the Applicant and probation

78. Dr. [redacted] and Dr. [redacted] tried repeatedly to discuss the Applicant's difficulties with him but he would frequently respond by becoming inpatient and angry. On some occasions the Applicant would later apologize for his behavior.

79. Numerous other supervisors also tried repeatedly to counsel the Applicant on his problem behaviors.

80. On May 29, 2012, Drs. [redacted] and [redacted] gave notice to the Applicant that they were sending him to the Faculty and Staff Assistance Program (FASAP) as a condition of his continued participation in the residency program (referred to in some of the exhibits as a COE – condition of employment). The Applicant was advised, "[W]hile in some areas you are consistently ranked quite strong for your medical knowledge and creative approaches to care, we have received a disturbingly high number of reports that your relationships with faculty and staff are strained, at best, because of your interpersonal and communication skills and behavior." Board 255.

81. The notice referred the Applicant to [redacted], Psy.D., at FASAP.

82. Ms. [redacted], Clinical Supervisor of the [redacted] FASAP, acted as a liaison between the Applicant, his department, and his treatment providers. When the Applicant was referred to the Professional Assistance Committee (discussed below), she continued in the liaison role, assisting the Applicant in complying with the requirements of his probation and advising his department and the PAC about his participation.

83. In addition to meeting with Ms. [redacted], the Applicant was obligated to submit to an evaluation and comply with any resulting recommendations including but not limited to monitoring, alcohol/drug screening, and psychotherapy.

84. The Applicant was already seeing a psychiatrist, Dr. [redacted] M.D., for quarterly visits, or more often, as needed. She assisted the Applicant with medication management, as he was taking medication for his OCD.

85. On May 30, 2012, the day after he was given notice of the requirement that he accept referral to FASAP, the Applicant met with Ms. [redacted] Board 641.

86. Ms. [redacted] arranged for the Applicant to attend therapy with [redacted]

87. Based on the findings of the OIE, released July 19, 2012, and the Applicant's performance in his residency, [redacted] notified the Applicant by letter dated August 1, 2012, that it was putting him on probation for an indefinite period of time.

88. The probation conditions included requirements that the Applicant focus on areas including but not limited to the following:

- treating all members of faculty, staff and housestaff in a respectful, courteous and dignified manner
- communicating with all staff members in a respectful manner that promotes effective team functioning and facilitates the best care for patients
- maintaining an appropriate professional decorum in interactions with staff members and patients without inappropriate joking, lack of seriousness or inattentiveness
- dependably attending and timely performing duties, including promptly responding to requests by nursing staff or supervisors
- demonstrating motivation to improve by receiving feedback from faculty, supervisors, peers, and training directors in a respectful, reflective manner.

Board 213-214.

89. The probationary conditions also required that the Applicant:

- comply with the recommendations of the PAC for evaluation and any treatment or follow up care;
- engage in therapy or other treatment by a mental health professional through a referral from FASAP or UMH;
- attend monthly meetings with Drs. [redacted] and [redacted]
- complete an OIE course on preventing sexual harassment.

90. Ms. [redacted] arranged a referral for the Applicant to see [redacted] Ph.D., for a neuropsychological evaluation based on a PAC recommendation.

91. Drs. [redacted] and [redacted] documented in September 2012 that the Applicant "has not met the expectations of our program with respect to interpersonal communication skills and professionalism." Board 243.

92. The Applicant met with Ms. [redacted] through March 20, 2013.

93. The Applicant's probation was terminated effective April 9, 2013, however the FASAP referral as a COE remained in effect.

94. The Applicant did not schedule an appointment with Ms. [redacted] in April 2013. In early May, Ms. [redacted] emailed the Applicant asking him to call to schedule his next appointment. The Applicant was resistant to scheduling. He eventually agreed to attend a closing appointment on June 20, 2013. The Applicant advised that he was going to California to start a Fellowship in Gerontology. Ms. [redacted] offered to assist the Applicant in finding a therapist in California, since his sessions with [redacted] had ended. The Applicant advised that he would make contact if he wanted assistance. The Applicant never contacted Ms. [redacted] for help in finding a therapist in California.

The [redacted] Report

95. Dr. [redacted] conducted a neuropsychological evaluation of the Applicant on October 4 and November 4 and 11, 2012. This was arranged by Ms. [redacted], in her role as liaison.

96. The resulting report noted that the Applicant is an "exceptionally intellectually gifted individual." Board 573. It also stated of the Applicant that:

> A second vulnerability is that he does not seem to be intuitively very competent at "reading" people and social situations. Again, this may be caused by the impingement on attentional resources described above, or may be a

separate issue in itself that, along with his rigidity, may place him mildly on the Aspergers/Autism spectrum."

Board 573.

Initial application to practice medicine in Maryland and interaction with the Board

97. On January 20, 2012, the Applicant filed his Application with the Board.

98. Page 9 of the Application contains an eighteen-question section titled "Character and Fitness Questions." It asked, among other things:

> c. Has any licensing or disciplinary board (including Maryland), or a comparable body in the armed services, filed any complaints or charges against you or investigated you for any reason?
>
> . . .
>
> e. Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?
>
> f. Has a hospital, related health care facility, HMO, or alternative health care system denied your application for, or failed to renew your privileges; or limited, restricted, suspended or revoked your privileges in any way?

Board 472.

99. When he filed his application on January 20, 2012, the Applicant answered these questions in the negative.

100. On August 15, 2012, the Applicant called and spoke with someone at the Board and advised that he was on probation at [redacted]. During the conversation, the Applicant mentioned "sexual harassment." Board personnel instructed the Applicant to submit a signed, dated, written statement about the probation and to review and revise page 9 of 11 of his Application.

101. The Applicant did not submit any written statement to the Board, nor did he revise page 9 of his Application.

102. On March 27, 2013, the Board wrote to the Applicant observing that he had not submitted any of the material requested of him on August 15, 2012, and reiterating its request that the Applicant submit those materials.

103. On April 11, 2013, the Applicant faxed to the Board a revised Application page 9, changing his answers to yes for question c (Has any licensing or disciplinary board (including Maryland), or a comparable body in the armed services, filed any complaints or charges against you or investigated you for any reason?) and e (Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?). Board 534.

104. Also on April 11, 2013, the Applicant faxed his response to the Board's request for a written statement. It addressed the conditions of his probation and advised that as of April 9, 2013, he was no longer on probation. The statement made no mention of the reasons why he had been placed on probation.

105. On April 25, 2013, the Applicant faxed to the Board a copy of the April 10, 2013 letter sent to him by Drs. [redacted] and [redacted] advising the Applicant of the termination of his probation effective April 9, 2013. The letter recognized the Applicant's satisfactory progress while on probation.

106. May 28, 2013, the Applicant was interviewed by the Board.

107. On July 9, 2013, the Applicant advised the Board that on July 6, 2013, he was granted a full, unrestricted license to practice medicine in California and that he had a change of address.

108. By notice dated June 12, 2014, the Board advised the Applicant of its intention to deny his Application for Initial Medical Licensure.

109. When the Applicant filed the initial application, he answered "no" to the question, "Do you have any physical or mental condition that currently impairs your ability to practice medicine or that would cause reasonable questions to be raised about your physical, mental, or professional competency?". The Applicant is obligated to notify the Board if the answer to that question changes while his application is pending. The Applicant has never updated or changed the answer to that question. Board 534.

While in California

110. On completion of his one-year Gerontology Fellowship in California, the Applicant stopped taking the medication prescribed by his psychiatrist.

111. On November 30, 2014, the Applicant's hospital privileges were terminated at San Diego Psychiatric Hospital, where the Applicant had been working for three months in a locum tenans position, that is, a temporary contractual position.

112. The Applicant would like to appeal the decision of San Diego Psychiatric Hospital to terminate his privileges.[18]

113. The Applicant did not notify the Board of this termination of his privileges.

114. The Applicant characterized the reasons stated by the hospital as the basis for his dismissal as, "I had disagreed with several other people, mostly in the administration at the hospital" and also a patient privacy issue. T 324.

DISCUSSION

Backgound

The Applicant filed his Application with the Board on January 20, 2012. The Board has the power to deny a license to an applicant for any of the reasons that are listed as grounds for

[18] The Applicant testified that he notified the medical director of the hospital that he "would like to appeal the decision" and that he had no further information on the status of any appeal as of the time of the hearing. T 256-257.

action against a licensee. HO § 14-205(b).[19] The Board served notice of its intention to deny the Applicant's application relying on two grounds.

First, the Board alleges that the Applicant is guilty of unprofessional conduct in the practice of medicine. This is a ground for action against a licensee under HO section 14-404. Second, the Board alleges that the licensee does not meet the requirements of HO section 14-307 which says that for an applicant to qualify for a license the applicant "shall be of good moral character."

The Applicant acknowledges that some of his conduct could, strictly speaking, qualify under case law as unprofessional conduct. The Applicant argues, though, that there are special circumstances in this case which should result in the Board granting him a license to practice medicine – circumstances that mitigate the unprofessional nature of the conduct and steer the analysis away from questions of moral character and into the realm of psychiatric diagnoses and the notion of compassion. I will begin the analysis with a discussion of whether, without consideration of the special circumstances suggested by the Applicant, the conduct he engaged in constitutes unprofessional conduct in the practice of medicine and whether the Board has proven by a preponderance of the evidence that the Applicant lacks good moral character. I will then consider the evidence adduced by the Applicant and its impact on these questions.

Legal framework – unprofessional or immoral conduct

In the context of medical licensure, the Maryland Court of appeals has defined unprofessional and immoral conduct as "conduct which breaches the rules or ethical code of a

[19] When the Board issued notice of its intent to deny the Applicant's application, it cited to HO section 14-205(a)(1)(iii) for this authority. The statute has since been revised. A completely new subsection (a) was added and the section formerly designated as (a) was changed to (b). Additionally, the highlighted language below was added to what is now subsection (b)(1)(iii) which enumerates powers of the Board: "Subject to the Administrative Procedure Act, deny a license to an applicant or, *if an applicant has failed to renew the applicant's license*, refuse to renew or reinstate an applicant's license for any of the reasons that are grounds for action under § 14-404 of this title[.]" None of the changes affect the substance of this case.

profession, or conduct which is unbecoming a member in good standing of a profession." *Finucan v. Maryland Bd. of Physician Quality Assurance*, 380 Md. 577, 593 (2004) quoting *Shea v. Bd. of Medical Exam'rs*, 81 Cal.App.3d 564 (1978). When the Board[20] brought charges against Dr. Finucan, HO section 14-404(a)(3) authorized the Board to discipline a licensee who was guilty of "immoral or unprofessional conduct in the practice of medicine," thus the Court's discussion did not distinguish between immoral and unprofessional conduct.

The statute has since been amended to split into two distinct subsections the issues of being guilty of "immoral conduct in the practice of medicine" and being guilty of "unprofessional conduct in the practice of medicine." This case encompasses allegations of both unprofessional conduct and lack of moral character, although the latter is charged under HO section 13-407(b), rather than HO section 14-404(a)(3)(i). This effectively broadens the scope of the conduct being evaluated. HO 13-407(b) calls for an examination of the Applicant's whole moral character, whereas HO 14-404(a)(3)(i) is limited to consideration of what takes place while the Applicant is engaged in the practice of medicine. It also makes the *Finucan* definition cited above relevant to this case despite the changes in the statute.

The HO Article defines the term "practice medicine" as follows:

> (o)(1) "Practice medicine" means to engage, with or without compensation, in medical:
> (i) Diagnosis;
> (ii) Healing;
> (iii) Treatment; or
> (iv) Surgery.
>
> (2) "Practice medicine" includes doing, undertaking, professing to do, and attempting any of the following:
> (i) Diagnosing, healing, treating, preventing, prescribing for, or removing any physical, mental, or emotional ailment or supposed ailment of an individual:

[20] When disciplinary charges issued against Dr. Finucan, the Board was known as the Board of Physician Quality Assistance. While the case was pending it became known as the State Board of Physicians.

1. By physical, mental, emotional, or other process that is exercised or invoked by the practitioner, the patient, or both; or
2. By appliance, test, drug, operation, or treatment;
(ii) Ending of a human pregnancy; and
(iii) Performing acupuncture as provided under § 14-504 of this title.

(3) "Practice medicine" does not include:
(i) Selling any nonprescription drug or medicine;
(ii) Practicing as an optician; or
(iii) Performing a massage or other manipulation by hand, but by no other means.

Md. Code Ann., Health Occ. § 14-101(o).

Maryland's Courts have also offered guidance to refine what "in the practice of medicine" means in physicians' disciplinary proceedings. In *Bd. Of Physician Quality Ass. v. Banks*, 354 Md. 59 (1999), Dr. Banks was a house physician for a hospital. He worked long shifts and was available to diagnose, treat, or admit patients to the hospital, although, because the position was new and hospital staff had not yet learned how to best use a house doctor, he was not often called upon to actually perform these duties. While on duty, Dr. Banks interacted with three staff members in ways that brought him to the attention of the Board.

With staff member #1, Dr. Banks often touched her, pinching her bottom, running his hands through her hair, or rubbing her shoulders or neck. He came up behind her on one occasion and reached around her squeezing her stomach. The staff member told him to stop and made it clear his attention was unwanted. Much of the contact occurred where patients, members of the public, or other staff could see it. His behavior with this staff member also included rude and offensive remarks, often sexual in nature. *Banks*, 354 at 62-63.

With staff member #2, Dr. Banks hit her on her backside very hard, asked her out after being told to leave her alone, and, after being told by staff member #2 that she had spilled coffee on herself, suggested that she should let him "lick it off." *Banks*, 354 Md. at 63. Dr. Banks

asked nineteen-year-old staff member #3 to go out with him for drinks. She declined and told him she had a boyfriend. On another occasion Dr. Banks caught staff member #3 outside the ladies room and pinned her to a wall, asking her sexually themed questions. An orderly working in the hospital happened by and pulled Dr. Banks off of Staff member #3. *Banks*, 354 Md. at 63-64.

The Board charged Dr. Banks with being guilty of immoral or unprofessional conduct in the practice of medicine under HO 14-404(a)(3) (again, this is before the statute was amended to its current form). Dr. Banks took the position that none of these activities occurred while he was engaged in the practice of medicine because he was not diagnosing, healing, treating, etc., at the time and thus his case should be dismissed. The case wound its way up to the Court of Appeals. After reviewing relevant Maryland case law and surveying cases from other jurisdictions, the Court of Appeals found: "[w]hen a hospital physician, while on duty, in the working areas of the hospital, sexually harasses other hospital employees who are attempting to perform their jobs, the Board can justifiably conclude that the physician is guilty of immoral or unprofessional conduct in the practice of medicine." *Banks*, 354 Md. at 76-77.

All of the behavior exhibited by the Applicant took place in the hospital or was so inextricably bound up in his residency that it qualifies as activity undertaken in the practice of medicine save two incidents. The incident of sexual intercourse and the incident at the bar cannot reasonably be said to have occurred in the practice of medicine. These incidents should be considered in answering the question of whether the Applicant is of good moral character, but not in answering the question of whether the Applicant is guilty of unprofessional conduct in the practice of medicine.

Credibility

Before discussing details of the Applicant's behavior, I will address some credibility issues, particularly regarding the two main witnesses – the Applicant and Dr. [redacted]. The Applicant was not credible in some of his testimony. Sometimes he tried to avoid answering questions. The transcript contains examples of the Applicant answering a question he was not asked rather than the one he was and he had to be redirected. Sometimes his answer simply did not ring true. For example, as discussed in more detail below, the Applicant delayed providing a statement to the Board about why he was on probation until the day after he learned his probation had ended. When asked about the seven to eight month lag in his response, the Applicant testified that he did not know why he delayed. The timing belies this testimony.

But even when he was trying to sincerely convey accurate information, the Applicant's version simply does not match what others saw or would see when observing the same events. His inability to read other people and to assess situations as the vast majority of individuals would assess them leads him to perceive and recount events in a way that may or may not be accurate in a way idiosyncratic to him, but which certainly is not reliable in the usual sense of the word.

For example, the Applicant filed a sexual harassment claim with OIE. He made an appointment to come in to discuss his complaint with OIE but then cancelled, saying he feared retaliation. Ms. [redacted] called and spoke with the Applicant, trying to follow up on his concerns. She even secured the Applicant's permission to speak with his residency supervisors. Ms. [redacted] then followed through and contacted the residency supervisors.

When a complaint was filed against the Applicant, Ms. [redacted] continued to investigate all allegations. She tried repeatedly to get the Applicant to come in to talk to her. Prior to his

arrival at OIE for his February 14, 2012 appointment, the Applicant had been yelling at Ms. [redacted]'s administrative assistant over the phone. Upon his arrival, the Applicant was angry, argumentative, and uncooperative. He was yelling at Ms. [redacted] so loudly that her supervisor heard it through the wall and instructed her not to meet alone with the Applicant. The Applicant accused Ms. [redacted] of being biased against him and demanded that she be replaced as the investigator on the case. Ms. [redacted] testified that she is accustomed to people being reluctant or anxious or angry when having to speak with OIE. The Applicant's demeanor and behavior, though, was extreme. She was sufficiently alarmed that she locked the office door after he left.

The Applicant subsequently wrote in an email to another [redacted] professional that Ms. [redacted] had "displayed unbelievable bias" in favor of Dr. [redacted]. When he was finally interviewed by OIE months later the Applicant "had the perception that I had already been judged," and did not handle it "in as intelligent manner and mature manner as I should have." T 279.

Of this entire situation the Applicant now says:

> I believe, going back, that Ms. [redacted] was not biased against me. I think she did – I was just unfamiliar with the entire process and I believe she [as] thoroughly investigated [redacted] as she did me.
>
> I feel like I did have an element of just paranoia in general and…I think that it stemmed from me knowing that there had been complaints about me from people I had worked with, and me just not knowing what to expect.

T 281.

The Applicant's vehement and inaccurate perception of Ms. [redacted] and the OIE investigatory process and his subsequent acknowledgement of how wrong he was demonstrate how difficult it is to accept the Applicant's testimony at face value. This is not an isolated example. The Applicant misunderstood or misconstrued or failed to notice or ignored the

perceptions of others - the realities of a situation - on many occasions and it makes evaluating his testimony difficult.

Dr. [redacted] appeared as a witness only because the Board required it. Throughout her association with the Applicant, she did not report his harassing behavior until he filed a baseless sexual harassment complaint against her. Even then, she took the steps she believed necessary to protect herself against the sexual harassment complaint but did not go any farther, such as complaining to the Board. She considered the Applicant to be a friend and she overlooked his faults for a very long time.

Dr. [redacted] also was vulnerable during part of their residency. She was attacked by her ex-boyfriend in September 2010, shortly after beginning her residency at [redacted] in July 2010. In the aftermath, she suffered from PTSD and had to take medications which she knew were affecting her performance. She had to share her personal situation with the residency program directors to explain why she was having difficulty staying awake and also why she was having other problems. She absolutely did not want to draw any additional attention to herself. Complaining about the Applicant would have done exactly that. She chose to remain silent until the Applicant filed with OIE.

On the stand, Dr. [redacted] was asked to relive painful and unpleasant moments. She did so in a manner consistent with being forced to discuss events one would rather forget. She testified that she has forgiven the Applicant and harbors no ill will towards him. She would simply like to be left alone to move on in her career. Nothing in her demeanor or testimony suggested anything other than that she was compelled to testify by the Board and she gave matter-of-fact answers to the questions she was asked. I found her to be a credible witness.

I found the other witnesses all to be credible. The State presented Dr. [redacted] in addition to Dr. [redacted] and Ms. [redacted] The Applicant provided testimony from Dr. [redacted] and Ms. [redacted].

Applying the law to the facts

Turning then to the Applicant's conduct, I note that listing out the facts serves to minimize the Applicant's conduct. His sexual innuendos, comments, and attempts at humor were *relentless*. Only a sampling is recounted in the Findings of Fact and it is important to emphasize that these are some of the most egregious or more memorable of his comments, but they represent a tiny fraction of the times he made others uncomfortable or disrupted the medical treatment or education of others. Further, the incidents highlighted in this proposed decision deal almost exclusively with the Applicant's interaction with peers or supervisors, but the Board's exhibits make clear that nurses, clerks, and other hospital treatment team members were also complaining about the Applicant's behavior and comments. It is also the case that the Applicant was receiving regular feedback about the inappropriateness of his comments. Drs. [redacted] and [redacted] many other supervisors, peers, and others were telling him fairly constantly that he was out of line. This did not seem to impact the Applicant's behavior.

The Applicant sexually harassed Dr. [redacted]. Shortly after meeting her, the Applicant, who was married at the time, physically assaulted Dr. [redacted] by pushing her in a closet-like room in a bar and trying to engage in sexual contact. This conduct took Dr. [redacted] by surprise and upset her. She told a friend about it the day it happened.

Around the same time, the Applicant anonymously sent multiple inappropriate messages to Dr. [redacted] through the [redacted] paging system, including saying she was "hot" – a message he had sent to another colleague while he was in PGY I in Pittsburgh. He came into Dr. [redacted]'s

office and tried to touch or rub her breasts. He made numerous sexual comments to her. She pushed him away, she told him to stop, she told him to get out of her office, but he kept right on repeating these behaviors about two times a week over a period of months.

In evaluating the conflicting statements regarding the episode of sexual intercourse, I do not find credible the Applicant's statements that Dr. [redacted] was a willing, happy, and active participant, even taking the lead. I find credible Dr. [redacted]'s testimony that she did not drink often and that on this occasions she was very affected by drinking on an empty stomach. I believe her when she says that she felt the effects of the alcohol and went to lie down. I am not sure, by a preponderance of the evidence, what happened after that. I believe that Dr. [redacted] now sees the incident as non-consensual and an indiscretion on her part, as she testified. I must recognize, however, that Dr. [redacted] stated that in the aftermath of the attack on her by her boyfriend she had memory problems and also that she was quite affected by the alcohol she consumed that night. In assessing whether the Applicant acted in a manner displaying a lack of moral character, I am not assigning any weight to this episode.

The friendship between Dr. [redacted] and the Applicant cooled for a while but then the Applicant began appearing in Dr. [redacted]'s office again, bringing up sexual topics and asking if they could be "friends with benefits." On at least one occasions the Applicant came into Dr. [redacted]'s office and told her he had an erection and asked if she could help him with it. He tried to rub himself against either Dr. [redacted] r the chair she was sitting in in conjunction with having an erection. The Applicant also embarrassed Dr. [redacted] in front of professional peers and a faculty member by walking past her and then reaching back to trail his hand over her abdomen while remarking on her physical appearance. The faculty member who observed the interaction was shocked by what she saw. Dr. [redacted] tried to downplay the incident in the

face of being asked, "What the hell was that?" She felt, however, that the Applicant was displaying a complete lack of respect for her and while that happened frequently, it usually did not happen so openly in front of others. The Applicant called her a "dirty whore" and a "nasty bitch" because Dr. [redacted] did not want him arriving late to relieve her at the end of her shift.

In addition to sexually harassing Dr. [redacted] the Applicant made comments to others as well, such as suggesting that Dr. [redacted] must like women because she got her hair cut short, or inviting a colleague to meet him at the sleeping room. He approached a doctor from the back and wrapped his arms around her, resting them on her pregnant belly. He sent an offensive email that was insulting on more than one level as it belittled mental health treatment and included dancing and singing about examination of male testicles. He disrupted classes or lectures with comments about dentists committing rape when they engage in dentistry because there is penetration or joked about his need to check the ID of a partner next time so as not to end up having sex with an underage individual. His presence on the floor was sufficient to prompt female residents to close their doors rather than having to interact with him.

Many of these behaviors echo those of Dr. Banks in the case outlined above – unwanted touching, suggestive remarks, or not taking "no" for an answer. The Court in *Banks* observed:

> The Board was justified in holding that Dr. Banks's conduct posed a threat to patients, not only because a "hospital environment must at all times be conducive to the practice of medicine," but also because his conduct was a threat to the teamwork approach of health care which requires participation from a variety of hospital personnel in order to deliver effective patient care. In fact, the evidence shows that Dr. Banks's conduct affected the working environment so deleteriously that it caused hospital employees to avoid him…Obviously Dr. Banks's misconduct could easily have an adverse effect upon patient care.

Banks, 354 Md. at 75. The same is true for the Applicant.

In addition to the problems outlined above, the Applicant also engaged in other unprofessional behavior. The Applicant's interaction with Ms. [redacted] in a professional setting

was marked by his yelling, glaring, smirking, wrongly accusing Ms. [redacted] of being biased and unable to conduct a fair investigation, and refusing to participate in the investigation he triggered while simultaneously complaining that it was taking too long.

The Applicant was abusive to Dr. [redacted], his supervisor in the PED. Disagreeing is fine, but when the Applicant called Dr. [redacted] to argue about being removed from rotation, he was nasty and personally insulting, questioning Dr. [redacted]'s character, her intelligence, and her professional competence. At a meeting scheduled with a residency director to discuss the issue, the Applicant could not or did not control himself and he raised his voice, again becoming very personally insulting to a physician to whom he gave very high marks when asked to evaluate her performance as a supervisor. He ended up leaving the meeting and slamming the door.

The Applicant was given very specific instructions by his residency supervisor not to return to rotation until he apologized to Dr. [redacted] and discussed with her certain aspects of patient care. The Applicant completely disregarded these directives and showed up for his next shift without speaking to Dr. [redacted]. When he later disagreed with her evaluation scores for him, he again called her on her cell phone and berated her with insults and yelling. As a consequence of the second call, Dr. [redacted] as Ms. [redacted] had before her, decided never to meet with the Applicant again alone. The Applicant was not just upset and blowing off steam. His intensity and unreasonableness caused two professional women – one who investigates sexual harassment complaints for a living and one who routinely interacts with emergency room mental health patients – to decide they would not meet alone with the Applicant.

The Applicant also had rocky relationships with Drs. [redacted] and [redacted] his residency supervisors. He treated them rudely, became angry with them, and impatiently brushed off their

attempts to assist or counsel him until they made certain items a condition of continued participation in the residency and later of probation.

In addition to these interpersonal difficulties, there are problems evident in the Applicant's dealings with the Board. The Applicant filed his complaint with OIE on November 30, 2011. He did not file his Application with the Board until January 20, 2012, yet he answered in the negative to a question asking if any hospital had ever investigated him. After [redacted] placed the Applicant on probation he called the Board in August 2012 and advised that he had been placed on probation. He was instructed to submit a written statement about the probation and to review and revise Page 9 of his Application. The Application itself contained this requirement in a section numbered 21, which is set off in a block by itself and requires a signature just for this single requirement, in addition to other required signatures:

> During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application…or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-404.

Board 474.

The Applicant did not provide any written statement and he did not submit a revised Page 9. A little over seven months later, on March 27, 2013, the Board sent a letter to the Applicant reiterating its request for a written response. The Applicant did not respond to this request until April 11, 2013. His response was problematic in two respects: the timing and the content.

The Applicant was obligated to advise the Board, if he did not know at the time of the filing of his application, within thirty days of his finding out that he was under investigation by [redacted] He learned that he was under investigation substantially contemporaneously with the filing of his Application, but made no attempt to advise the Board until after he was placed on formal probation, a delay of six to eight months. Then, having called to notify the Board about his

probation, the Applicant delayed an additional seven-and-a-half to eight months before he provided any correction to his Application or any written statement. The delay is inexcusable. When asked on direct examination if he had any "clarification" about why there was a delay between the August Board request and the April submission, the Applicant answered, "No. No I don't. I should not have delayed." T 289-290.

The Applicant waited over seven months before he responded to the Board, but he responded *the day after* he learned he was no longer on probation. This demonstrates that the timing was no accident or oversight – it was calculated and manipulative. The Applicant was deliberately delaying a response. This is further seen in the other material the Applicant spontaneously sent to the Board. On April 25, 2013, the Applicant faxed a letter to the Board which he stated he had received that same day. The letter confirmed the termination of his [redacted] probation. On July 9, 2013, the Applicant faxed the Board to report that he had been granted a full, unrestricted license to practice medicine in the State of California three days earlier. The preponderance of the evidence showed that the Applicant knew that he was required to update the Board, and did so promptly when the news was favorable to him, but simply ignored requirements and requests when he did not wish to share negative information.

At the time of the hearing, the Applicant's privileges were terminated at the San Diego hospital where he had been practicing for about three months. The details of the termination are unclear and the only information available is that provided by the Applicant, which, for the reasons identified above, is subject to his idiosyncratic interpretation, but, he reported that it had to do, in part, with his disagreement with hospital employees. Had the Applicant reported to the Board the hospital's action in terminating his privileges, as he is required to do while his application is still pending, the Board would have had the opportunity to investigate. Because I

have so little reliable information about the termination itself, I give the termination little weight in this proposed decision as a whole, but I do find the Applicant's failure to disclose unfavorable information to the Board relevant to his truthfulness.

Turning then to the content of the written statement the Applicant ultimately provided, the Applicant told the Board in August during the phone call that his probation was related to sexual harassment, but provided no details. When he finally submitted his written statement in April 2012, the Applicant did not mention anything about why he had been placed on probation. He discussed the requirements of his probation and asserted that he had complied with all listed conditions, but he never offered any outline of what happened or why he was put on probation.[21] This omission is, as the Board suggested, "glaring."

The Applicant's attempts to conceal information by failing to advise the Board he was under investigation, failing to provide information to the Board when it was required and requested, and providing incomplete information to the Board speak to the Applicant's veracity and credibility. Maryland cases have held that making false statements to the Board or falsely answering questions on license renewal applications is misconduct occurring in the practice of medicine. *Cornfeld v. State Board of Physicians*, 174 Md.App. 456 (2007) (false statements to

[21] When interviewed by the Board on May 28, 2013, the Board interviewer was trying to get a sense of why the Applicant was placed on probation. With respect to the sexual harassment he was found by the OIE to have perpetrated, he was asked, "[w]hat happened?" He answered:

> And I had a brief dating relationship with [Dr.] for approximately two months. And I ended that relationship. And a time after that I began dating another individual in no way affiliated with the program. And [Dr. was jealous and began, I thought, saying hurtful things to me during the course of work, and teasing me, even intimidating me at work.
>
> So I filed – some of these comments that she made were, I thought, a sexually belittling nature. I filed a complaint with the [OIE]…And she filed a counter-complaint and that's the nature of the harassment.

Also during the interview, the Applicant was asked to give an example of what he had said to others (not Dr that was alleged to be inappropriate: "Q: Can you give me an example? A: I mean, I can't. Q: So you were never made aware of what they actually had said or what the issues were? A: No. I was told several of the complaints. I can't recollect right now what they were."

Board 553. The Applicant's credibility is further damaged by these types of answers.

hospital investigatory bodies or the Board are misconduct); *Kim v. Maryland State Bd. of Physicians*, 423 Md. 523 (2011) (false answers on medical license renewal are misconduct in the practice of medicine).

The Applicant's willful disregard of his obligation to update his Application and provide a written statement, especially after having been specifically instructed to do so, is misconduct in the practice of medicine which reflects poorly on the Applicant's truthfulness. In the context of admission to the Maryland Bar, the Court of Appeals had said, "[a]n applicant must possess good moral character for admission to any Bar, denoted by 'those qualities of truth-speaking, of a high sense of honor, of granite discretion, of the strictest observance of fiduciary responsibility.'" *In re Cramer*, 427 Md. 612, 622 (2012) (the *Cramer* decision cites to many other Maryland cases reiterating this statement). "[G]ood moral character includes truthfulness and candor, and absolute candor is a requisite of admission" to the Bar. *Cramer*, 427 Md. at 622. Although Cramer addresses candor in the context of Bar admission, is it instructive also on the general issue of moral character. It is just as critical for a physician to be candid as it is for an attorney. In his dealings with the Board, the Applicant displayed a lack of candor that is not only unprofessional conduct in the practice of medicine, but also demonstrates lack of good moral character.

The Applicant's arguments about mitigating circumstances

The Applicant has difficulties in reading people and situations. He lacks the filter most people have that assists them by internally reviewing things that might be said and nudging one to silence when the contemplated comment or joke might be inappropriate for the audience or would be likely to be misconstrued or overkill. The Applicant contends that it is inappropriate to find that he lacks moral character or to deny him a license to practice medicine in Maryland

based on unprofessional conduct that results from his not being able to discern the non-verbal cues and situational realities around him.

The Applicant started by arguing that he has Asperger's or is on the autism spectrum. The Applicant has never been diagnosed with Asperger's, anything on the autism spectrum, or any developmental disorder. He based his argument on the findings of Dr. [redacted] who conducted neuropsychological testing on the Applicant as required either by PASAC or PAC, or both. Dr. [redacted]'s report was entered into evidence by the Board as a medical record of the Applicant obtained by subpoena.[22] In the "Synthesis and recommendations" section of the report, Dr. [redacted] observes that the Applicant is "exceptionally intellectually gifted" but that he has a "history of social difficulties." Board 573. The report continued:

> [The Applicant] has difficulty inhibiting his tendency to speak and behave somewhat impulsively and in managing himself in a way that his recent and academic history would suggest is consistent with a diagnosis of ADHD. Additionally he endorses significant related symptomatology. Based on clinical experience with very high functioning individuals, it often seems to be the case that their potent cognitive gifts are not always matched by their level of executive control so that the internal stimulus is more compelling than the external one. Thus, the social strictures that might inhibit expressing an idea, even when correct, tend to be overwhelmed. In at least some of the instances in which [the Applicant] seems to have run into problems, this seems to be a feature of his difficulties.
>
> Added to this innate imbalance of abilities, [the Applicant] had two other vulnerabilities entering the [redacted] program. One is [that] his Obsessive-Compulsive Disorder, from which [the Applicant] suffers, seems to be caused by a dysfunction of orbital-frontal inhibition which prevents "hard-wired" grooming and checking behaviors from expressing themselves. In itself, the attentional demands that actively managing these non-automatically restricted impulses makes can be fatiguing, and interfere with self-regulation in other domains. Whether this is another expression of a larger inhibitory dysfunction or whether it is sufficient in itself to demand resources that would otherwise be used to in (sic) self-regulation in social situations, making them more effortful is difficult to say.

[22] There was no discussion of Dr. [redacted]s credentials and no stipulation as to his expertise in any field. He was not called to testify. Because the Applicant relied so heavily on this report, I address the statements contained therein without deciding whether Dr. [redacted]s training and expertise in the field of psychology or neuropsychology qualified him to draw the conclusions stated in his report, and without the benefit of any testimony to assist in interpreting the report's meaning.

A second vulnerability is that he does not seem to be intuitively very competent at "reading" people and social situations. Again, this may be caused by the impingement on attentional resources described above, or may be a separate issue in itself that, along with his rigidity, may place him mildly on the Aspergers/Autism spectrum.

This is far too tenuous to be considered a diagnosis of Asperger's or anything on the autism spectrum. The report issued in late 2012 and the Applicant discussed it with Dr. [redacted] his treating psychiatrist from November 2010 through June 2013. Dr. [redacted] did not diagnose the Applicant as having any autism spectrum disorder. Furthermore, the Applicant has seen psychiatrists, psychologists, or therapists throughout his life and the Applicant has never been diagnosed as being on the autism spectrum. The Applicant, when asked if he considered himself to be on the autism spectrum, could only bring himself to say, "It's a possibility." T 315. There is insufficient evidence, even judged by a preponderance standard, to show that the Applicant is on the autism spectrum.

The Applicant did not provide any expert medical testimony regarding clinical reasons for his interpersonal difficulties or causal relationships between confirmed diagnoses and those difficulties. Dr. [redacted] and Dr. [redacted] testified for the State as fact witnesses. The State did not offer either one as an expert and did not attempt to qualify either to testify as to medical matters. On cross-examination, the Applicant asked questions of Dr. [redacted] regarding medical issues. Based on an objection that was raised there was some discussion about whether a question called for an expert opinion or not. During cross and again during redirect I pointed out that Dr. [redacted] had not been qualified as an expert.[23] The Applicant's witnesses, Dr. [redacted] and [redacted] also were not offered as expert witnesses. The record establishes

[23] Dr. [redacted] in testifying about the time she called the Applicant a sociopath, stated, "At that time I believed that he was [a sociopath], and probably still believe that, because he violated the rules and had no remorse for his behavior." T 163. So even though the Applicant tried to elicit medical testimony regarding the Applicant's possible diagnoses and possible signs and symptoms of those diagnoses from Dr. [redacted], it is doubtful that he truly wants all her testimony to be accepted as that of an expert.

certain diagnoses for the Applicant, but does not explain what everybody agrees is a difficulty he experiences with social interaction.

The Applicant was placed on a COE and referred to FASAP. He was already seeing a psychiatrist at that point. He was sent to Ms. [redacted] to coordinate his COE obligations. He subsequently was placed on probation. As a consequence, he was required to continue to see his psychiatrist and take recommended medications, undergo medical testing, submit to neuropsychological testing, begin regular therapy sessions, meet monthly with Drs. [redacted] and [redacted] for monitoring and feedback, and meet regularly with Ms. [redacted] Under these extremely structured conditions, the Applicant enjoyed a period of relative success. He was released from his probation and *immediately* became resistant to meeting with Ms. [redacted] even though he was still under the COE.

The Applicant testified about how helpful therapy was to him. For example:

> Q: And to what extent, if any, did your treatment by a therapist enable you to modify or prevent similar conduct [unintentionally offending others] after you were placed on probation?
> A: It made an enormous difference to me. I had been very reluctant to speak with – or I had been entirely reluctant and did not speak with anybody, friends, family, about these difficulties I'd had, and it was really the first time I'd had an opportunity to speak with someone openly and receive their feedback and suggestions to try different approaches and, in return, discuss the success or the result of different approaches to interacting with other people. So it, to me, was invaluable. It made an enormous difference.

T 262-263.

When interviewed by the Board, on May 28, 2013, just before he left for California, the Applicant was asked:

> Q: So when you get to California since all of these support systems are in place here in Maryland…what are you going to do to avoid any pitfalls when you get to California?

A: Well, I certainly would like to continue seeing a therapist. And I will still need at least medication management for OCD. I would like to continue seeing a psychiatrist for that reason.

Board 556-557.

About a month later, the Applicant ceased attending therapy. Ms. ████ offered to help the Applicant connect with a therapist in California, but the Applicant declined. The Applicant apparently experienced difficulty as a result of discontinuing therapy:

Q: And did you continue therapy after the conclusion of your residency?
A: I did not.
Q: Why not?
A: I mistakenly assumed that I had corrected my problems, that given the success I had had during therapy, I would be able to sustain that by myself without additional help.

T 266. The Applicant continued on medication for about a year, and then stopped taking medication as well.

It is not clear what kept the Applicant on track while he was on probation. It could have been a combination of some or all of the probationary conditions, or the looming threat of being dismissed from the residency program or something else entirely. What is clear is that the Applicant jettisoned the various pieces of assistance that had been carefully crafted and put in place to help him gain insight and achieve his goals. Even the therapy, which he said he found invaluable and intended to continue, was discarded.

The Applicant offered in his opening statement that the Applicant potentially could undergo:

> …cognitive behavioral management. Once [the Applicant] was referred to counselors, once he was given medication to assist with his impulsive OCD, and so on, as Dr. ████ and the other codirector mentioned, his trajectory, so to speak, as they termed it, improved significantly.

> And that…is the basis upon which I am going to premise my request…not to deny [the Applicant] licensure, but rather to impose such surveillance, if you will, on his practice to ensure that he does comply with the remedial aspects which will allow him to practice in Maryland if he chooses.

T.54.

The Applicant stated in his closing memorandum that "with appropriate accommodations and treatment, [the Applicant] can be a productive, contributing and, indeed, outstanding member of the psychiatric medical community" and "evidence of a pathological etiology for the behavior offers the clear potential for effective management of the disorders and the avoidance of chronic repetition of such conduct in the future."[24] The Applicant has elected not to pursue the means that he argues offer a clear potential for effective management of his unacceptable lapses of moral character and his unprofessional conduct in the practice of medicine. He complained about his probation while he was on it, sought to end it as quickly as possible, even just a few weeks after it was imposed,[25] and he stopped attending therapy[26] and taking medication. He is not in a position to demand that the Board craft a program to try to reconstruct the supports he dismantled and grant him a license to practice medicine in Maryland.

The Applicant did not offer any specific suggestions for how to structure a restricted license. Dr. concluded:

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[24] It is not clear how these statements mesh with the Applicant's closing memorandum assertion that he 'is not contending nor has he ever contended that his diagnoses of OCD, ADHD, and potential Asperger's syndrome impair his ability to practice his profession." This dovetails with the Board's argument that, if the Applicant has some medical or psychiatric condition that impacts his ability to practice medicine, he would be obligated to change additional answers on his Applicant, updating the Board on specifics.

[25] *See* Board 786, 788, 789, 790, and 791 notes from . Note of 8/24/12 – the Applicant was anticipating a favorable evaluation and, if he got one, "plans to f/u [follow up] with Dr. to see if this will remove his probation."; Note of 10/26/12 the Applicant had a meeting scheduled with Drs. and and "hopes they will consider taking him off probation[.]"; Note of 1/14/13 the Applicant "met with Dr. and Dr. and …told that the probation will not be lifted any time soon. He is very upset…"; Note of 2/19/13 the Applicant voiced "disappointment at not having his probation lifted[.]"

[26] Dr. 's report recommended that the Applicant form "a stable, regular therapeutic relationship focusing on improving his social interactions[.]" Board 574.

> One of the striking things in talking to [the Applicant] is that he is a perspicacious clinician who seems to be very good at thinking about the big picture. The same contrarian tendencies that get him into trouble when it is hard for him to inhibit them also lead him to ask very cogent questions. At the end of the day, he has the type of mind that is very well-suited for a clinical researcher and/or a consultant if he can 1) find more adaptive ways of interacting with colleagues, and 2) can sustain his interest through long projects.

Board 573. The same report noted that the Applicant had previously been interested in biomedical engineering, but "found the research environment [too] isolating." Board 569. The Applicant, on cross-examination, conceded that he would not need a medical license to practice as a clinical researcher. T 321. He also could do some consulting without a medical license, but that would have limitations. T 321.

> In original admissions to the Maryland Bar, the test of present moral character is whether, "viewing the applicant's character in the period subsequent to his misconduct, he has so convincingly rehabilitated himself that it is proper that he become a member of a profession which must stand free from all suspicion."

Application of Hyland, 339 Md. 521, 535, (1995), cited with approval in *Cramer*, 427 Md. at 622. Again, the quoted language comes from a case on Bar admission, but sheds helpful light on the questions of moral character in a professional licensing context. The Applicant's recent failure to notify the Board of the termination of his privileges at a California hospital and his current circumstances of being without a therapist or medication to assist in managing his behavior fall short of a showing by the Applicant that he has "convincingly rehabilitated" himself.

Summary

The Applicant has engaged in unprofessional conduct in the practice of medicine and he has demonstrated a lack of the moral character required for licensure to practice medicine. The Board may deny an initial license to practice medicine on either of these grounds. The Applicant has failed to prove that autism or any other specific diagnosis explains either the unprofessional

conduct or the moral lapses. He has also failed to prove that he is entitled to require the Board to issue any type of restricted license or license with conditions to allow him to engage in some type of medical practice in the State of Maryland.

PROPOSED CONCLUSIONS OF LAW

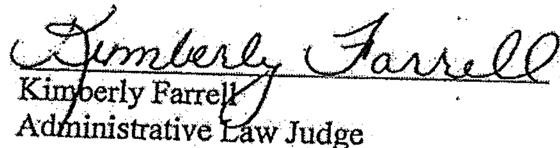
Based on the foregoing Findings of Fact and Discussion, I propose that the Board conclude as a matter of law that the Respondent engaged in unprofessional conduct in the practice of medicine in violation of HO sections 14-205(a) and 14-404(a)(3)(ii); *Bd. Of Physician Quality Ass. v. Banks*, 354 Md. 59 (1999); *Kim v. Maryland State Bd. of Physicians*, 423 Md. 523 (2011); *Cornfeld v. State Board of Physicians*, 174 Md. App. 456 (2007). I further propose that the Board conclude as a matter of law that the Applicant lacks the good moral character required to practice medicine under HO section 14-307(b). *Bd. Of Physician Quality Ass. v. Banks*, 354 Md. 59 (1999); *Kim v. Maryland State Bd. of Physicians*, 423 Md. 523 (2011); *In re Cramer*, 427 Md. 612 (2012); *Cornfeld v. State Board of Physicians*, 174 Md. App. 456 (2007).

As a result, I propose that the Board deny the Application to practice medicine submitted by the Applicant on January 20, 2012. HO sections 14-404(a)(3)(ii) and 14-307(b).

PROPOSED DISPOSITION

I **PROPOSE** that the Board's **DENIAL** of the Applicant's January 20, 2012 Initial Application to Practice Medicine be **UPHELD.**

April 3, 2015
Date Decision Issued



Kimberly Farrell
Administrative Law Judge

KAF/kkc
Document #154582

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party may file exceptions to this proposed decision with the Board of Physicians and request a hearing on the exceptions. The exceptions must be written and be filed within fifteen (15) working days from the date of the proposed order. COMAR 10.32.02.11C(8). The exceptions and request for hearing must be addressed to the Board of Physicians, 4201 Patterson Avenue, Baltimore, MD, 21215-2299, Attn: Geneva Goode, Administrative Aide to Supervisor, Compliance Administration.

A copy of the exceptions should be mailed to the opposing attorney. The opposing party will have fifteen (15) days from the filing of any written exceptions to file a response. *Id.* The response must be addressed as above. *Id.* The Office of Administrative Hearings is not a party to any review process.

Copies mailed to:

Ryan Greytak, MD
1241 Prospect Street, Apt. 10
La Jolla, CA 92037

Thomas Morrow, Esquire
Shaw, Morrow & Joseph, P.A.
Executive Plaza III, Suite 1200
11350 McCormick Road
Hunt Valley, MD 21031

Christopher B. Anderson, Assistant Attorney General
Administrative Prosecutor
Health Occupations Prosecution and Litigation Division
Office of the Attorney General
300 West Preston Street, Room 201
Baltimore, MD 21201

Rosalind Spellman, Administrative Officer
Health Occupations Prosecution and Litigation Division
Office of the Attorney General
300 West Preston Street, Room 201
Baltimore, MD 21201

Christine Farrelly, Acting Executive Director
Compliance Administration
Maryland Board of Physicians
4201 Patterson Avenue
Baltimore, MD 21215

Andrea Mathias, M.D., Chairman
Maryland Board of Physicians
Metro Executive Plaza
4201 Patterson Avenue, Third floor
Baltimore, MD 21215

John Nugent, Principal Counsel
Health Occupations Prosecution and Litigation Division
Office of the Attorney General
300 West Preston Street, Room 201
Baltimore, MD 21201