IN THE MATTER OF	**BEFORE THE**
ERIC C. GREENBERG, M.D.	**MARYLAND STATE**
Respondent	**BOARD OF PHYSICIANS**
LICENSE NUMBER: D0050275	**Case Number: 7720-0016**

AMENDED FINAL DECISION AND ORDER

Eric C. Greenberg, M.D. (the "Respondent") was initially licensed to practice medicine in 1996 by the Maryland State Board of Physicians (the "Board"). The central issue in this case is whether the Respondent violated terms and conditions imposed by Disciplinary Panel B ("Panel B") of the Board in an Order of Reinstatement with Conditions, issued on August 16, 2019 (the "2019 Reinstatement Order"). On March 3, 2025, Panel B charged the Respondent with violating the 2019 Reinstatement Order by: using a Controlled Dangerous Substance ("CDS") not prescribed for a legitimate medical purpose, in violation of his Participant Rehabilitation Agreement ("PRA") and Participant Rehabilitation Plan ("PRP") with the Maryland Professional Rehabilitation Program ("MPRP"); failing to comply with the evaluation ordered by MPRP; and failing to respond to MPRP's directives.

BACKGROUND AND DISCIPLINARY HISTORY

The Respondent has an extensive disciplinary history with the Board that preceded the 2019 Reinstatement Order. Since 2006, the Respondent has been subject to repeated discipline by the Board based on violations of the Mayland Medical Practice Act (the "Act"), Md. Code Ann., Health Occupations ("Health Occ.") §§ 14-101 *et seq.* (Lexis Nexis Supp. 2025). The Board imposed disciplinary sanctions in 2006, 2007, 2009, and 2011 before issuing the 2019 Reinstatement Order. For almost two decades, the Board provided the Respondent with many opportunities for extensive remedial education, training, and monitoring, with the goal of

enabling him to conform his non-compliant and unprofessional conduct, medical care, and record documentation to appropriate standards.

Consent Order, May 24, 2006

On May 24, 2006, the Respondent voluntarily entered into a Consent Order with the Board where he was found to be in violation of Health Occ. § 14-404(a)(33) for failure to cooperate with a Board investigation because he failed to undergo a physical examination as ordered by the Board pursuant to Health Occ. § 14-402(a). The Board placed the Respondent on probation with conditions. The Respondent complied with the conditions, and the probation was subsequently terminated on August 3, 2006.

Consent Order, June 27, 2007

On June 27, 2007, the Respondent voluntarily entered into a second Consent Order in which the Board concluded that he engaged in unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii); failed to meet appropriate standards for the delivery of quality care, in violation of Health Occ. § 14-404(a)(22); and failed to keep adequate medical records in violation of Health Occ. § 14-404(a)(40). The Board placed the Respondent on probation for a period of three years with conditions that included a prohibition on prescribing medication to family members and a requirement that he abstain from mood altering and controlled dangerous substances unless prescribed for legitimate medical purposes.

Summary Suspension, April 16, 2009

On April 16, 2009, pursuant to Md. State Gov't. Code Ann. §10-226(c)(2), the Board determined that the public health, safety, or welfare imperatively required emergency action, and summarily suspended the Respondent's medical license for reasons including, but not limited to,

prescribing medication to family members, excessively prescribing controlled dangerous substances ("CDS"), and for violating the conditions of his June 27, 2007 Consent Order.

Final Decision and Order, May 19, 2011

On May 19, 2011, after an evidentiary hearing and exceptions process, the Board found that the Respondent violated: Health Occ. § 14-404(a)(3)(ii) (unprofessional conduct in the practice of medicine; Health Occ. § 14-404(a)(4) (professionally, physically, or mentally incompetent); and Health Occ. § 14-404(a)(27) (prescribes drugs for illegitimate medical purposes). The Board also concluded that the Respondent violated conditions of the June 27, 2007 Consent Order by prescribing medication to family members and by not abstaining from certain substances prohibited under that Consent Order. As a result, the Board revoked the Respondent's license to practice medicine in Maryland.

Denial of Application for Reinstatement, May 18, 2016

On May 18, 2016, Panel B denied the Respondent's application for reinstatement of his medical license. Panel B found that while the Respondent had made several improvements, the Panel still had concerns about his insufficient insight into his prior actions, his inability to show that he appreciated or understood the nature or gravity of his past conduct, and the Panel's lack of adequate assurance that the Respondent would not repeat the conduct that led to the revocation.

Order of Reinstatement with Conditions, August 16, 2019

On August 16, 2019, Panel B issued an Order of Reinstatement with Conditions, reinstating the Respondent's license to practice medicine in Maryland with permanent conditions that included prohibitions on prescribing or dispensing CDS, seeing or treating patients at his home, or practicing in an independent practice setting. The 2019 Reinstatement Order also

imposed a five-year period of probation and required the Respondent to enroll in MPRP, and to enter into a Participant Rehabilitation Agreement ("PRA") and Participant Rehabilitation Plan ("PRP") with MPRP. The Order further required that Dr. Greenberg:

> shall fully and timely cooperate and comply with all of MPRP's referrals, rules, and requirements, including but not limited to, the terms and conditions of the [PRAs] and [PRPs] entered into with MPRP, and Dr. Greenberg shall fully participate and comply with all therapy, treatment, testing, and evaluations as directed by MPRP;

The Order also required that:

> Dr. Greenberg shall also sign ay written release/consent forms to authorize MPRP to exchange with (i.e. disclose to and receive from) outside entities (including all of Dr. Greenberg's current treatment providers) verbal and written information concerning Dr. Greenberg and to ensure that MPRP is authorized to receive the medical records of Dr. Greenberg, including, but not limited to, mental health and drug or alcohol treatment records. Dr. Greenberg shall not withdraw his release/consent;

In addition, the Order stated that:

> if Dr. Greenberg allegedly fails to comply with any term or condition imposed by this order, Dr. Greenberg shall be given notice and an opportunity for a hearing. If a disciplinary panel determines there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings followed by an exceptions process before a disciplinary panel; and if a disciplinary panel determines there is no genuine dispute as to a material fact, Dr. Greenberg shall be given a show cause hearing before a disciplinary panel; and it is further
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> **ORDERED** that, after the appropriate hearing, if the disciplinary panel determines that Dr. Greenberg has failed to comply with any term or condition of this order, the disciplinary panel may reprimand Dr. Greenberg, place Dr. Greenberg on further probation with appropriate terms and conditions, or revoke Dr. Greenberg's license to practice medicine in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon him; and it is further
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> **ORDERED** that a violation of probation or of a permanent condition constitutes a failure to comply with a term or condition of this order[.]

Violation of 2019 Order of Reinstatement with Conditions

By email dated September 19, 2024, an MPRP representative notified the Board of a toxicology test result collected from the Respondent on September 4, 2024, which was positive for a CDS. The test results also noted that a retest had been performed on September 18, 2024 "due to customer request" and that the results were confirmed on the retest. By email dated November 19, 2024, an MPRP representative notified the Board that the Respondent was discharged from the program for cause effective November 18, 2024. The attached closure letter stated in part:

a) The Respondent completed a long-term dried blood spot ("DBS") toxicology screening as part of his anticipated final toxicology screening on September 4, 2024. The screening resulted positive for a CDS. The sample was tested for reconfirmation and the results remained positive for the same CDS.

b) The Respondent denied using the CDS and requested a hair test. MPRP agreed to explore other confirmatory options and advised the Respondent that a hair test was not an available option.

c) On September 23, 2024, MPRP requested that the Respondent undergo a comprehensive evaluation and provided the Respondent with the location for the evaluation. MPRP later provided an alternative evaluation location at the Respondent's request.

d) The Respondent failed to provide MPRP with scheduling confirmation by October 9, 2024, as required. The Respondent insisted on completing a hair test after being informed multiple times that the hair test was not an available option.

e) MPRP provided the Respondent with an opportunity to complete a virtual evaluation and requested scheduling confirmation by October 28, 2024. On October 25, 2024, the Respondent emailed the evaluator to schedule the evaluation but did not sign the appropriate

release of information documentation until November 1, 2024. The Respondent was also unresponsive to the evaluator's requests for pre-admission documents. Ultimately, the evaluation never took place.

f) On or about November 15, 2024, an MPRP representative contacted the Respondent by phone and left him a voice message to inquire about the status of the virtual evaluation. The Respondent did not return the call but continued to engage with MPRP's toxicology portal. Based on instructions provided to him on the portal, he submitted a urine sample for urinalysis on November 8, 2024. By November 19, 2024, the Respondent had not contacted MPRP regarding the virtual examination status.

In an email dated December 2, 2024, an MPRP representative notified the Board that urinalysis test results collected from the Respondent on November 8, 2024, came back positive for the metabolite of the CDS. The test results were reviewed by a medical review officer ("MRO") who stated that the results indicate that the Respondent ingested the CDS within one to four days of the test.

The Board sent three letters to the Respondent after receiving notice of his two positive toxicology tests and his ultimate discharge from MPRP. In his written responses to the Board, the Respondent failed to provide an explanation for his noncompliance with the evaluation requested by MPRP and his lack of response to MPRP directives.

SUBSEQUENT PROCEDURAL HISTORY

Following receipt of the foregoing information from MPRP and the written responses from the Respondent, Panel B charged the Respondent, on March 3, 2025, with violating the terms and conditions of the 2019 Reinstatement Order. Panel B also notified the Respondent that

a Show Cause Hearing was scheduled for April 23, 2025, at 10:30 A.M., at the Board's office, 4201 Patterson Avenue, Baltimore, Maryland 21215.

During the Show Cause Hearing before Panel B on April 30, 2025, Panel B determined that a material fact was in dispute. Pursuant to COMAR 10.32.02.14C, Panel B terminated the Show Cause Hearing and delegated the matter to the Office of Administrative Hearings ("OAH") for an evidentiary hearing before an Administrative Law Judge ("ALJ") on whether the Respondent violated the terms and conditions of the 2019 Reinstatement Order, and the issuance of proposed findings of fact, proposed conclusions of law, and a proposed disposition. COMAR 10.32.02.04B(1)(c).

On October 20 and 21, 2025, an ALJ held a remote evidentiary hearing via the Webex videoconferencing platform. At the hearing, the ALJ admitted into evidence twenty-seven exhibits on behalf of the State and thirteen exhibits on behalf of the Respondent. The Administrative Prosecutor for the State presented testimony from a Board probation supervisor and a clinical manager for MPRP, in addition to expert testimony from two licensed physicians certified as Medical Review Officers (MROs) - State Expert 1 and State Expert 2 - who testified regarding addiction medicine, the sample collection process, and toxicology results. The Respondent was represented by counsel and testified on his own behalf.

On January 14, 2026, the ALJ issued a proposed decision recommending that the charges be upheld, and concluding as a matter of law, that the Respondent violated the terms and conditions of the 2019 Reinstatement Order. As a sanction, the ALJ proposed that the Respondent's medical license be revoked.

The ALJ's proposed decision to the parties contained a Notice of Right to File Exceptions ("Notice") to the proposed decision and to request a hearing on the exceptions with the

disciplinary panel of the Board that delegated the case to OAH. The Notice informed the parties that they must do so within fifteen (15) days of the date of issuance of the proposed decision on January 14, 2026. In addition, the proposed decision notified the parties that the exceptions and hearing request should be addressed to the disciplinary panel of the Board, that a copy of the exceptions should be mailed to the opposing party, that the other party would have fifteen (15) days from the filing of exceptions to file a written response, and that the disciplinary panel would issue a final order following the exceptions hearing. The proposed decision was mailed to the parties at their respective addresses of record.

On January 22, 2026, the Board notified the Respondent, his counsel, and the State that written exceptions were due at the Board on February 2, 2026, and any response to the exceptions was due on February 18, 2026. The Board further notified the parties that the exceptions hearing was scheduled for March 11, 2026, before Disciplinary Panel A at the Board's address. On February 2, 2026, in a written submission, the Administrative Prosecutor for the State requested that Panel A adopt the ALJ's proposed factual findings and legal conclusions. The State agreed with the ALJ's conclusion that a sanction of revocation was necessary but argued that permanent revocation was required to more effectively protect public health, safety, and welfare based on the Respondent's conduct over the past 20 years. The Respondent did not file written exceptions to the ALJ's proposed decision or any response to the State's exception regarding the ALJ's proposed sanction.

On March 11, 2026, this case came before Disciplinary Panel A of the Board for final disposition. The Respondent did not appear at or participate in the scheduled exceptions hearing, nor did anyone appear on his behalf.

FINDINGS OF FACT

Panel A adopts the parties' Stipulations of Fact ¶¶ 1-10[1] and the Findings of Fact ¶¶ 1-30 proposed by the ALJ.[2] (The ALJ's Proposed Decision of January 14, 2026, is incorporated by reference into this Final Decision and Order and is appended to this Order as Exhibit A. Panel A also adopts the ALJ's Discussion, Analysis and Conclusions of Law on pages 10-33 of the Proposed Decision. The findings of fact, summarized below, were proven by a preponderance of the evidence.

At all relevant times, the Respondent was and is licensed to practice medicine in the State of Maryland, License Number D0050275, with an expiration date of September 30, 2026. The Respondent's disciplinary history with the Board and sanctions imposed from 2006 – 2019 are undisputed. The conditions of the 2019 Order of Reinstatement, including the requirements that the Respondent's enroll in MPRP, cooperate with all of MPRP's referrals, rules and requirements, including the terms and conditions of the PRA and PRP, and comply with all therapy, treatment, testing and evaluations as directed by MPRP, are similarly undisputed.

On September 5, 2019, the Respondent signed the PRA which prohibits use of "any illicit substance," and required that he not "consume any controlled substances or mood-altering substances" unless "prescribed in an appropriate manner for a legitimate medical purpose." The Respondent also signed an Addendum to the PRA entitled "Toxicology Protocol, Procedures and Agreement" which explains the range of samples that could be collected and warns that it is the participant's responsibility to "reduce 'false positives.'" The agreement specifies that if a participant requires "additional materials to better understand how 'false positives' can happen,

[1] The parties stipulated to these facts from the *Violation of Order of Reinstatement with Conditions* issued to the Respondent on March 3, 2025.

[2] The ALJ's Findings of Fact ¶¶ 1-7, 17, 27(f), and 29, incorporated the parties' Stipulations of Fact ¶¶ 1-10.

the program staff will provide you with that material." The Addendum to the PRA "further states, in bold text, that "Any positive test results, regardless of any explanations, will be considered a violation" by the Board and may be used "to impose additional sanctions.'" In addition, the PRA and PRP required the Respondent to undergo random toxicology testing, including alcohol, a CDS, and/or its metabolite when the CDS is metabolized by the body. He would be notified of the test date and type of sample to be collected through the MPRP portal.

The Respondent lives with family members and has not been prescribed the CDS since 2013. During his five-year probation under the 2019 Order of Reinstatement, the doctor of one of his family members prescribed the CDS in two forms, a patch placed on the hip and a liquid medication. Another family member's doctor prescribed the CDS in pill form.

On September 4, 2024, the Respondent submitted three blood spots for use in a dried blood-spot ("DBS") toxicology test pursuant to MPRP portal instructions that included washing his hands multiple times and sanitizing the skin using an alcohol swab. The sample was collected using a sealed kit with all necessary components, including a barrier to place on the table or countertop to avoid contamination of the sample. Collection of the DBS sample takes place while a proctor observes the process by video. The proctor's role is to ensure that a participant follows the proper procedures to maintain the integrity of the sample.

On September 19, 2024, an MPRP representative notified the Board that a toxicology test result from the Respondent's September 4, 2024 test sample was positive for the CDS, and was 24.3 ng/mL (nanograms per milliliter), an amount that exceeds the reference range of 5 to 20 ng/mL Such an amount is consistent with a therapeutic dose of the CDS, and would not be caused by incidental contact with a CDS patch or residue from liquid medication. At the

Respondent's request, a retest was performed on September 18, 2024 on another of the three blood spots collected on September 4, 2024, and the retest confirmed the presence of the CDS.

In disputing the positive DBS test result, the Respondent requested a hair analysis, which was scheduled for September 24, 2024, but canceled because MPRP was informed that the CDS was not one of the panels covered and would not give MPRP the comprehensive information needed in his case. Based on concerns by MPRP's clinical team, the MPRP clinical manager also arranged for the Respondent to set up a comprehensive in-person evaluation through the University of Florida, but he declined to do so due to the cost and travel and his disagreement with its inclusion of a polygraph test. He requested to work with a local provider and a hair sample analysis despite being advised multiple times that a hair test was not an available option. In early October, the clinical manager informed the Respondent that an acceptable evaluator was available in Chicago, and asked him to schedule the evaluation, but he failed to do so. On October 24, 2024, she informed him that he could instead complete a virtual evaluation through another provider, which was scheduled for the week of November 4, 2024.

On October 26, 2024, the Respondent was informed that he needed to sign a Release of Information ("ROI") form so the evaluation could proceed. The clinical manager and the Respondent exchanged emails regarding the ROI terms and information, which he wanted to limit. On October 31, 2024, he was notified that he was required to submit the signed ROI by 5 pm on November 1, or his case would be closed for cause. The Respondent did not submit the signed ROI until after the deadline. A virtual evaluation rescheduled for November 18, 2024, was subsequently canceled because he failed to complete and submit the required pre-admission documents. The Board was notified by email on November 19 that the Respondent was discharged from the program on November 18, 2024.

Although the Respondent continued to engage with MPRP's toxicology portal, and submitted a urine sample for urinalysis on November 8, 2024 based on portal instructions, he did not respond to emails and phone calls from MPRP representatives. By email dated December 2, 2024, MPRP notified the Board that the Respondent's urinalysis test results from the November 8, 2024 sample were positive for the metabolite of the CDS. An MRO who reviewed the test results opined that the results indicated the Respondent's ingestion of the CDS within one to four days of the test.

ANALYSIS

Use of the CDS Before the Final Toxicology Test

At the hearing, the Respondent adamantly denied any use of the CDS and contended that the State failed to show that he intentionally and knowingly used the drug, rather than accidentally ingesting it. He reasoned that after five years of negative toxicology tests, it would have been "ridiculous" for him to "sabotage" himself by using the CDS just before his final toxicology test. Based on his expertise in addiction medicine, State Expert 1 testified that a relapse in substance use is not unusual despite successful abstinence from such use for several years. The ALJ found that the Respondent's reliance on the assumption that it would have been ridiculous for him to engage in such an absurd and irrational act was not evidence that he did not use the CDS just before his final toxicology test. Panel A agrees with the ALJ's determination that: (1) the irrationality of relapsing and using the CDS at that time had virtually no weight in analyzing whether such use occurred when contrasted with the documented positive toxicology tests in his case; (2) his denial could not be reconciled with the objective reality of the positive DBS test result reflecting a CDS level consistent with a therapeutic dose of 24.3 ng/mL; and (3)

the credibility of his denial was further undermined by the positive urine test for the metabolite of the CDS two months later in November 2024.

Sample Contamination

The Respondent also argued that contamination of samples by those handling them or inadvertently by himself was a more likely and reasonable alternative explanation for the positive test results. The ALJ, however, concluded that no reliable evidence supported the Respondent's arguments that the positive results were caused by contamination during the sample collection process, or by subsequent handling of the samples by the testing facilities, or by incidental exposure due to the Respondent's own handling or accidental ingestion of his family members' medication.

In weighing the expert testimony and explanations of the State's MROs regarding the validity of the Respondent's toxicology results, the ALJ considered the specific, detailed testing steps taken throughout the DBS testing process. These steps included State Expert 2's demonstration of the process with a kit and trifold card on which the individual being tested places blood spots, the lancet, gauze, the video-proctored and recorded specimen collection in one sitting, the creation of a sanitized barrier, and the observation of the specimen collection by a proctor with a checklist in hand to ensure integrity and compliance with all cleansing procedures during the entirety of the process. Noting that the Respondent presented no evidence of a flawed process or errors in the lab's subsequent handling of the sample, the ALJ found it extremely unlikely that the collection process or lab handling procedures resulted in contamination of his September 4, 2024 DBS sample. In her judgment, a licensed physician like the Respondent is certainly aware of the importance of complying with skin cleansing and sanitizing instructions to

prevent infection and contamination. Accordingly, she found no basis to conclude that his ability to understand and comply with the explicit cleaning instructions was compromised in any way, or that the proctor failed to ensure his compliance.

As for the Respondent's handling of his family member's CDS patch, State Expert 2 testified that based on that sample collection process and instructions to ensure clean hands, there would be "zero likelihood" of contamination from a substance on the Respondent's skin. This expert also testified that the therapeutic level of 24.3 ng/mL is an amount too high to be explained by incidental contact with his family member's patch or even accidental ingestion of any residue from a container used to give liquid medication. The expert further testified that when he called the Respondent to inform him of the positive test result, the Respondent agreed that "residual or briefly touching" a patch would not result in that level of the CDS. The Respondent himself testified that contact with liquid residue was a very unlikely explanation for such a level.

State Expert 2 also refuted the Respondent's contention that one of the blood spots from the DBS test should have been tested for the metabolite of the CDS to rule out contamination. He explained that a blood sample would not be a reliable body fluid for evaluating the presence of the metabolite, as the blood would contain only very small amounts of the metabolized product that would be moving through the body's entire bloodstream. He clarified that the CDS has a short half-life, levels drop quickly, and the small amount of the metabolite present in the bloodstream would fall quickly reducing its concentration and making its detection in a blood sample difficult. In addition, based on the therapeutic level of the CDS detected in the Respondent's blood, State Expert 2 had already effectively ruled out possible contamination as a credible explanation.

MPRP requested that State Expert 1 interpret the result of the Respondent's November 8, 2024 urine sample that tested positive for the metabolite. This expert described the rigorous chain-of-custody and lab procedures used in handling urine samples, stating that samples that initially test positive are subject to confirmatory testing to rule out false positives. He opined that the confirmatory result of 113 ng/mL, a low level of metabolite, meant that the Respondent had ingested the CDS in one to four days prior to the test. He did not find the Respondent's denial of ingesting the CDS to have any validity and declined to confirm the Respondent's theory that handling his family member's patch might allow sufficient body absorption to produce this level of the metabolite. According to State Expert 1, he had never seen any studies that would support such a theory. The ALJ found the Respondent's theory even less plausible based on the November 8, 2024 urine test positive result which was collected two months after the DBS test result that he claimed was a false positive and he was already aware of potential problems with such incidental contact. The ALJ concluded that it severely undercuts his explanation that both the positive results could possibly be explained by this type of contact. Panel A agrees.

Alleged Time Delays

The Respondent also challenged the validity of the November 8, 2024 urine test based on time lapses between the sample collection on a Friday, the lab's receipt of the sample the following Wednesday, November 13, 2024, and the positive report of November 27, 2024, two weeks later. State Expert 1 testified that this was not an atypical timeline for processing the sample and reporting the test result, and if slower processing had any impact, it would make it more difficult to detect a substance but would not amplify a result. The ALJ found that the Respondent presented no evidence that the timeframe had any impact on the integrity of the sample or the accuracy or validity of the test result.

Test Reliability

Based on five anonymous reports[3] submitted to the Food and Drug Administration ("FDA") by individuals who identified themselves as patients and alleged that positive DBS results were false, the Respondent claimed that the DBS test is unreliable. Finding that the anonymous reports that the Respondent presented did not include indications that they had been acknowledged, reviewed, investigated, or verified by the FDA, the ALJ properly gave them no weight in her analysis.

The Respondent also alleged that the DBS test collection device and confirmation testing are not FDA-approved, which State Expert 2 did not dispute, but testified that certain components of the DBS card are FDA-approved, and FDA approval is not necessary for the tri-fold card itself. He also testified that confirmation tests, unlike screening tests, do not generally require FDA approval. As the ALJ found, the Respondent failed to identify any specific federal statute, regulation, guidance documents, or policies that contradicted the expert testimony on this issue, and she determined that his testimony was highly credible and uncontradicted. Nor did the Respondent provide evidence that the testing company, or manufacturer of the devices and tests it uses, have been charged with or found in violation of any provision of the Food and Drug Act or its implementing regulations. The ALJ, therefore, found no meaningful support in the record for treating the DBS test result as unreliable.

Confirmation Tests

The Respondent further asserted that valid confirmation tests were not performed to verify the positive toxicology results and argued that the DBS tests should have been confirmed

[3] One of the reports appeared to be from the Respondent to the FDA, as the AJ found it matched the facts of his case.

with other modality testing such as a hair test. While acknowledging that the initial DBS test was followed up with a second test on one of the other three blood spot samples he had provided, the Respondent contended that these were all from the same sample from a single finger prick and speculated that contamination from the presence of the CDS on his finger may have led to the positive DBS detected by the second test. Based on the repeated instances of cleaning/sanitizing required during the sample collection process and the expert evidence provided by State Expert 2, the ALJ found, and the Panel agrees, that there is no support in the record for the theory that skin contamination led to the positive DBS test result. Regarding confirmation of the tests, State Expert 2 also testified that the DBS test is tested for the specific substance, and samples undergo "gold standard" confirmatory testing methodology using liquid chromatography mass spectrometry, to ensure that "cross-reactivity" (a false positive result caused by a similar chemical substance) does not occur.

State Expert 1 testified that the November 8, 2024 urine sample underwent an initial screening, which can provide both false positives and false negatives, so any positive results are then subjected to confirmatory testing. This testing provides a "fingerprint" of the substance that is specific to that substance, quantifies the mount detected, and can refute a false positive screening test. State Expert 1 testified that he has never seen a false positive throughout his years of doing this kind of work. He also credibly testified that a hair test would have been "without value" in this case, because a negative hair test is not reliable evidence of abstinence and would not negate a positive toxicology test.

In addition, despite the Respondent's apparent assumption that a negative hair test would or should have changed MPRP's decision that a comprehensive evaluation was necessary in his case, MPRP's clinical manager testified that the decision was based not only on his positive DBS

test and prior history, but the difficult and combative behavior he exhibited during his interactions with them. She also informed the Respondent in an October 28, 2024 email that any specialized toxicology testing, which includes hair, would be at the discretion of any evaluators based on the comprehensive in-person evaluation arranged for him by MPRP. Ultimately, the Respondent was uncooperative with the evaluation process, even though MPRP accommodated his concerns with costs and logistics by subsequently planning a virtual multidisciplinary evaluation. The ALJ correctly determined that the Respondent was not discharged from the program because of the lack of a hair analysis to refute the positive toxicology test, but because he failed to follow through and cooperate with the comprehensive evaluation deemed necessary by MPRP.

State Experts' Testimony

Based on the testimony of State Expert 1 that the urinalysis test of 113 ng/mL for the metabolite was "relatively low," and the testimony of State Expert 2 that the therapeutic level of 24.3 ng/mL in the DBS test required the ingestion of a "large amount" of the CDS, the Respondent argued that the State's experts contradicted one another. In her analysis, the ALJ correctly concluded that the toxicology tests were of different modalities, used different body fluids, measured for different substances, and used samples collected over nine weeks apart. She found no contradiction in the testimony of the experts that compromised their credibility and also found that the higher therapeutic level of the CDS was far less compatible with the Respondent's explanation that exposure occurred through incidental skin contact of handling his family member's patch.

THE RESPONDENT FAILED TO COMPLY WITH THE 2019 REINSTATEMENT ORDER

It is undisputed that the Respondent did not comply with the evaluation requested and directed by MPRP. He admitted questioning the positive DBS toxicology result and resisting the MPRP decision to refer him for a comprehensive evaluation as a meaningful scientific confirmation of the result. The language of the 2019 Reinstatement Order, however, clearly and explicitly states that the Respondent "shall fully and participate and comply with all therapy, treatment, testing, and evaluations as directed by MPRP." The PRA similarly requires the Respondent to "obtain any medical, neurological, or psychological/substance abuse evaluations" recommended by MPRP. As the record shows, MPRP accommodated the Respondent's concerns about the cost and travel involved with the two evaluations arranged initially, by providing him with a third option and directing him to schedule a virtual evaluation with another available provider. It is also undisputed that the Respondent was informed on October 26, 2024, that he needed to sign a Release of Information ("ROI") form so that evaluation could proceed. He wanted to limit the information disclosed, however, and failed to submit the ROI by the deadline. After the evaluation was scheduled, the Respondent requested that it be rescheduled for November 18, 2024, a week later. The rescheduled evaluation was canceled because he did not respond to the provider's request to complete and submit pre-admission paperwork. Finally, the Respondent did not return a phone call from MPRP's clinical manager directing him to contact MPRP regarding the evaluation.

In summary, the facts and expert testimony submitted by the State reveal the implausibility of the Respondent's vague speculation that he unknowingly or accidentally ingested the CDS. Rather, he deliberately and knowingly did so. The Panel concurs with the ALJ

that his denial arguments and alternative explanations are neither persuasive nor supported by any credible evidence that undermines the validity of the positive toxicology results.

The Respondent failed to file any written or oral exceptions to the ALJ's proposed findings of fact or conclusions of law and has thus waived any arguments challenging the findings of fact or conclusions of law issued by the ALJ and adopted by Panel A. Similarly, the Respondent has waived any arguments with respect to the imposition of a sanction based on his failure to file any response to the State's exception to the ALJ's proposed sanction.

CONCLUSIONS OF LAW

Panel A concludes that the Respondent violated the Order of Reinstatement with Conditions issued on August 16, 2019, by failing to comply with MPRP's treatment recommendations and the terms of his Participant Rehabilitation Agreement and Plan.

SANCTION

For two decades, the Board has given the Respondent multiple opportunities to address the Board's concerns about his repetitive, troubling misconduct by re-educating him on the essential components of recovery and rehabilitation integral to safe medical practice. The Board's objective was to enable the Respondent to focus on his reparative needs, provide medical care and treatment within appropriate standards, prevent patient harm, and enhance patient safety. Based on the Respondent's successive violations, it is apparent that the Board's previous attempts to rehabilitate him were unsuccessful. Despite years of Board monitoring, it is obvious that he has learned little or nothing from the Board's remedial efforts and is unwilling or unable to do so.

The imposition of progressive discipline is a disciplinary tool essential to the Board's mission of protecting the public. The Respondent's propensity for minimizing his pervasive,

serious violations is deeply concerning, and the Panel concludes that his violations are not remediable. Panel A, therefore, grants the State's exception to the ALJ's proposed sanction of revocation. The Panel's statutory charge is to protect the public, and the Panel deems permanent revocation necessary to protect the public from the Respondent's continued practice.

ORDER

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

ORDERED, that the medical license of the Respondent, license number D0050275, is **PERMANENTLY REVOKED;** and it is further

ORDERED that the disciplinary panels will not accept any application for reinstatement from the Respondent; and it is further

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

I, Ellen Douglas Smith, sign this **ORDER** on behalf of Disciplinary Panel A.

08/27/2026
Date

Signature on File

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

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 14-408(a), Dr. Greenberg has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within thirty (30) days from the date of mailing of this Final Decision and Order. The date of the cover letter accompanying this final decision and order is 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. Greenberg 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:

Noreen Rubin
Assistant Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

Exhibit A

MARYLAND STATE BOARD OF	*	**BEFORE JENNIFER L. GRESOCK,**
PHYSICIANS	*	**AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE**
ERIC GREENBERG, M.D.,	*	**OF ADMINISTRATIVE HEARINGS**
RESPONDENT	*	
LICENSE No.: D50275	*	**OAH No.: MDH-MBP2-71-25-14149**

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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 March 3, 2025, the Maryland State Board of Physicians (Board) issued charges against Eric Greenberg, M.D., (Respondent) for alleged violations of the terms and conditions of an Order of Reinstatement with Conditions (Order) issued by the Board on August 16, 2019.[1]

The disciplinary panel to which the matter was assigned held a Show Cause Hearing on April 30, 2025. The Respondent, represented by Cory M. Silkman, Esquire, appeared at the Show Cause Hearing. As the Show Cause Hearing progressed, the disciplinary panel concluded that there was a genuine dispute as to a material fact. The disciplinary panel terminated the Show Cause Hearing before its completion and delegated the matter to the Office of Administrative Hearings (OAH), with the OAH receiving the transmittal on May 12, 2025.

[1] The August 16, 2019 Order followed a May 19, 2011 Final Decision and Order issued by the Board and finding the Respondent in violation of sections 14-404(a)(3)(ii); 14-404(a)(4); and 14-404(a)(27) of the Health Occupations Article of the Maryland Annotated Code. *See generally* The Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101 through 14-509; and 14-601 through 14-702 (2021 & Supp. 2025).

The delegation directs that I hold an evidentiary hearing regarding whether the Respondent violated the terms and conditions of the Order and issue proposed findings of fact, proposed conclusions of law, and a proposed disposition. COMAR 10.32.02.03E(5); COMAR 10.32.02.04B(1).

I held a remote hearing on October 20 and 21, 2025, via Webex. Health Occ. § 14-405(a); COMAR 10.32.02.04. Mr. Silkman represented the Respondent, who was present. Veronica Colson, Assistant Attorney General and Administrative Prosecutor, represented the State of Maryland (State).

The contested case provisions of the Administrative Procedure Act, the Rules for Hearings Before the Board, and the Rules of Procedure of the OAH govern procedure. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2021 & Supp. 2025); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

(1) Did the Respondent violate the terms and conditions of an Order of Reinstatement with Conditions, dated August 16, 2019, by:

- Using [redacted] in a manner that violates the Participant Rehabilitation Agreement (PRA) and Participant Rehabilitation Plan (PRP) the Respondent has with the Maryland Professional Rehabilitation Program (MPRP);
- Failing to comply with the evaluation requested by the MPRP; or
- Failing to respond to MPRP directives; and

(2) if the Respondent did violate the terms and conditions, what sanction, if any, is appropriate?

SUMMARY OF THE EVIDENCE

Testimony

The following witnesses testified on behalf of the State:

- Brooks H. Whigham, Probation Supervisor with the Board;
- [redacted] M.D., Certified Medical Review Officer (MRO), accepted as an expert in addiction medicine and on the review conducted by a certified MRO;
- [redacted] M.D., accepted as an expert in the review conducted by a certified MRO; and
- Amber Thrasher, LCSW-C,[2] Clinical Manager, MPRP.

The Respondent testified.

Exhibits

A complete exhibit list is attached as an Appendix.

STIPULATED FACTS AND PROPOSED FINDINGS OF FACT

I find the following facts by a preponderance of the evidence, except where a fact is noted to be a stipulation of the parties:[3]

1. At all relevant times, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on March 27, 1996, under License Number D50275. The Respondent's license is presently active and expires on September 30, 2026, subject to renewal.[4]

[2] Licensed Clinical Social Worker – Certified.
[3] I have lightly edited facts to which the parties have stipulated for stylistic consistency and, where necessary, for clarity. Stipulated facts are identified herein, and when so identified, are substantively consistent with the parties' written submission.
[4] The parties stipulated to this fact, identified as Finding of Fact #1.

2. On May 24, 2006, the Respondent voluntarily entered into a Consent Order with the Board where he was found to be in violation of the Maryland Medical Practice Act[5] for failure to cooperate with a Board investigation based on his failure to undergo a physical examination as ordered by the Board pursuant to section 14-402(a) of the Health Occupations Article of the Maryland Annotated Code. The Board placed the Respondent on probation with conditions. The Respondent complied with the conditions, and the probation was subsequently terminated on August 3, 2006.[6]

3. On June 27, 2007, the Respondent voluntarily entered into another Consent Order, whereby the Board concluded that the Respondent violated section 14-404(a)(3)(ii) by engaging in unprofessional conduct; 14-404(a)(22) by failing to meet the standards of quality medical care; and 14-404(a)(40) by failing to keep adequate medical records.[7] The Board placed the Respondent on probation for a period of three years with conditions.[8]

4. On April 16, 2009, the Board summarily suspended the Respondent for reasons including, but not limited to, inappropriately prescribing medication to family members, inappropriately prescribing controlled dangerous substances, and for violating the terms of his June 27, 2007 Consent Order.[9]

5. On May 19, 2011, the Board issued a Final Decision and Order, after an evidentiary and exceptions hearing, finding the Respondent in violation of subsections 14-404(a)(3)(ii), (4), and (27).[10] The Board also concluded that the Respondent violated conditions of the June 27, 2007 Consent Order by prescribing medication to family members and

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[5] Health Occ. § 14-404(a)(33).
[6] The parties stipulated to this fact, identified as Finding of Fact #2.
[7] These citations are to the Health Occupations Article of the Maryland Annotated Code.
[8] The parties stipulated to this fact, identified as Finding of Fact #3.
[9] The parties stipulated to this fact, identified as Finding of Fact #4.
[10] Md. Code Ann., Health Occ. § 14-404(a)(3)(ii): is guilty of unprofessional conduct in the practice of medicine; § 14-404(a)(4): is professionally, physically or mentally incompetent; § 14-404(a)(27): sells, prescribes, gives away, or administers drugs for illegal or illegitimate medical purposes.

by not abstaining from certain substances prohibited under the Consent Order. As a result, the Board revoked the Respondent's license to practice medicine in Maryland.[11]

6. On May 18, 2016, the Board denied the Respondent's application for reinstatement of his medical license, finding that while the Respondent had made several improvements, the Board was still concerned about the Respondent's lack of insight into his prior actions.[12]

7. On August 16, 2019, the Board issued an Order of Reinstatement with Conditions, reinstating the Respondent's license to practice medicine in Maryland with conditions that included, but were not limited to, a five-year minimum period of probation. The Respondent was also ordered, among other things, to enroll in the MPRP, and enter into a PRA and PRP with MPRP. The Order further required that the Respondent:

> shall fully and timely cooperate with all of the [MPRP]'s referrals, rules, and requirements, including but not limited to, the terms and conditions of the [PRAs] and [PRPs] entered into with MPRP, and [the Respondent] shall fully participate and comply with all therapy, treatment, testing, and evaluations as directed by MPRP.[13]

8. The PRA prohibits use of "any illicit substance," and required that the Respondent not "consume any controlled substances or mood altering substance" unless "prescribed in an appropriate manner for a legitimate medical purpose." The Respondent signed the PRA on September 5, 2019.

9. The MPRP provided the Respondent with an addendum to the PRA entitled "Toxicology Protocol, Procedures and Agreement," which he signed on September 5, 2019. This agreement explains the range of samples that could be collected and warns that it is the participant's responsibility to "reduce 'false positives.'" It specifies that if a participant requires

[11] The parties stipulated to this fact, identified as Finding of Fact #5.
[12] The parties stipulated to this fact, identified as Finding of Fact #6.
[13] The parties stipulated to this fact, identified as Finding of Fact #7.

"additional materials to better understand how 'false positives' can happen, the program staff will provide you with that material." It further states, in bold text, that "Any positive test results, regardless of any explanations, will be considered a violation" by the Board and may be used "to impose additional sanctions."[14]

10. [redacted] is a Schedule II Controlled Dangerous Substance (CDS) which affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. It is a central nervous system stimulant used to treat attention deficit hyperactivity disorder (ADHD) and narcolepsy.[15]

11. When [redacted] is metabolized by the body, the product is [redacted]

12. The Respondent has not been prescribed [redacted] since 2013.

13. The Respondent lives with [redacted] During the Respondent's probationary period, [redacted] doctor prescribed [redacted] in two forms, a patch placed on [redacted] hip and a liquid medication. [redacted] doctor prescribed [redacted] in pill form.

14. The Respondent's PRA and PRP require that he undergo random toxicology testing, including for alcohol, [redacted] He would be notified of the test date and the type of sample to be collected through the MPRP portal.

15. On September 4, 2024, pursuant to instructions from the MPRP portal, the Respondent submitted three blood spots for use in a dried blood-spot toxicology test (DBS test). This sample was collected using a sealed kit that contains all necessary components, including a barrier to place on the table or countertop as a barrier to avoid contamination of the sample.

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[14] State Ex. 28g.
[15] The facts to which the parties stipulated included this fact as a footnote.
[16] State Ex. 28g.

Additionally, the participant is instructed to wash his hands multiple times and to sanitize the skin using an alcohol swab.

16. Collection of the DBS sample takes place while a proctor observes the process by video. The proctor's role is to ensure that the participant follows the proper procedures to maintain the integrity of the sample.

17. By email dated September 19, 2024, an MPRP representative notified the Board of a toxicology test result which was positive for [redacted] for the Respondent. The test sample had been collected on September 4, 2024. The test results also noted that a retest had been performed on September 18, 2024 "due to customer request" and that the results were the same.[17]

18. The positive DBS test result from the September 4, 2024 sample was 24.3 ng/mL.[18] This amount exceeds the reference range of 5 to 20 ng/mL and is consistent with a therapeutic dose of [redacted] Incidental contact with a [redacted] patch or liquid [redacted] medication residue would not cause a test result in this range.

19. The DBS test result from September 18, 2024, was obtained from another of the three blood spots collected on September 4, 2024. The September 18, 2024 result confirmed the presence of [redacted] but, due to deterioration of the sample, did not quantify it.

20. The Respondent disputed the positive DBS test result and requested that a hair analysis be performed. Ms. Thrasher worked with the Respondent to set up a hair analysis, scheduling it for September 24, 2024.[19]

[17] The parties stipulated to this fact, identified as Finding of Fact #8.
[18] Nanograms per milliliter.
[19] State Ex. 28g.

21. Ms. Thrasher also arranged for the Respondent to set up a comprehensive in-person evaluation through the University of Florida.[20] However, a hair analysis was not available through this program.

22. While the Respondent was initially receptive to the evaluation, he changed his mind due to the cost and travel associated with the program, as well as its inclusion of a polygraph test. He requested that he be permitted to work with a local provider and be permitted to provide a hair sample.

23. In early October 2024, Ms. Thrasher informed the Respondent that an acceptable evaluator was also available in Chicago. She asked him to schedule the evaluation, but the Respondent failed to do so.

24. On October 24, 2024, Ms. Thrasher informed the Respondent that he could instead complete a virtual evaluation through another provider, All Points North.

25. On October 26, 2024, Ms. Thrasher informed the Respondent that he needed to sign a Release of Information (ROI) form so that his virtual evaluation, scheduled for the week of November 4, could proceed. Over the next several days, the Respondent and Ms. Thrasher exchanged emails regarding the terms of the ROI. On October 31, 2024, Ms. Thrasher notified the Respondent that if he did not submit the signed ROI by 5:00 p.m. on November 1, 2024, his case would be closed "for cause." The Respondent did not submit the signed ROI by the deadline.

26. The Respondent submitted the signed ROI on November 1 after the 5:00 p.m. deadline. However, a virtual evaluation scheduled for November 18, 2024, was subsequently cancelled because he failed to complete and submit required pre-admission documents.

[20] State Ex. 28n.

27. By email dated November 19, 2024, an MPRP representative notified the Board that the Respondent was discharged from the program for cause effective November 18, 2024. The attached letter stated in part:

a. The Respondent completed a DBS test as part of his anticipated final toxicology screening on September 4, 2024. The test resulted positive for [redacted] The sample was tested again and the results were the same.

b. The Respondent denied using [redacted] and requested a hair test. MPRP advised the Respondent that a hair test was not an available option.

c. On September 23, 2024, MPRP requested that the Respondent undergo a comprehensive evaluation and provided the Respondent with information for the location of the evaluation. MPRP later provided an alternative evaluation at the Respondent's request.

d. The Respondent failed to provide MPRP with scheduling confirmation by October 9, 2024, as required. The Respondent insisted on completing a hair test after being informed multiple times that the hair test was not an available option.

e. MPRP provided the Respondent with an opportunity to complete a virtual evaluation and requested scheduling confirmation by October 28, 2024. On October 25, 2024, the Respondent emailed the evaluator to schedule the evaluation but did not sign the appropriate release of information documentation until November 1, 2024. The Respondent was also unresponsive to the evaluator's requests for pre-admission documents. Ultimately, the evaluation never took place.

f. On or about November 15, 2024, an MPRP representative contacted the Respondent by phone and left him a voice message to inquire about the status of the virtual evaluation. The Respondent did not return the call but continued to engage with the MPRP's toxicology portal.[21]

28. On November 8, 2024, based on instructions provided to the Respondent in the portal, the Respondent submitted a urine sample for urinalysis.

29. By email dated December 2, 2024, an MPRP representative notified the Board that the Respondent's urinalysis test results from the November 8, 2024 sample were positive for [redacted] The test results were reviewed by an MRO who stated that the results indicate that the Respondent ingested [redacted] within one to four days of the test.[22]

30. The positive test result from the November 8, 2024 urinalysis was for [redacted]

DISCUSSION

Applicable Law

In Maryland, health occupations are regulated "to protect the health, safety, and welfare of the public." Health Occ. § 1-102(a) (2021). Section 14-404 of the Medical Practice Act sets forth the grounds on which a disciplinary panel of the Board may take disciplinary action against a licensed physician:

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
> . . .
>
> (3) Is guilty of:
> . . .

[21] The parties stipulated to this fact, identified as Finding of Fact #9.
[22] The parties stipulated to this fact, identified as Finding of Fact #10.

(ii) Unprofessional conduct in the practice of medicine;

(4) Is professionally, physically, or mentally incompetent;

(27) Sells, prescribes, gives away, or administers drugs for illegal or illegitimate medical purposes[.]

Health Occ. § 14-404(a)(3)(ii), (4), & (27). These violations are grounds for revocation. COMAR 10.32.02.10A; B(3)(e), B(4), & B(27). A disciplinary panel may reinstate a license after revocation through an order of instatement issued by the disciplinary panel; probation is among the disciplinary measures available to the panel.

Here, the State contends that the Respondent failed to comply with the probationary requirements of the Order, issued by the panel on August 16, 2019. The disciplinary panel charges the Respondent with violating the following provisions of the Order:

...

(4) [The Respondent] shall fully and timely cooperate with all of the MPRP's referrals, rules, and requirements, including but not limited to, the terms and conditions of the [PRAs] and [PRPs] entered into with MPRP, and [the Respondent] shall fully participate and comply with all therapy, treating, testing, and evaluations as directed by MPRP[.]

Additionally, the Order states:

ORDERED that, if [the Respondent] allegedly fails to comply with any term or conditions imposed by this order, [the Respondent] shall be given notice and an opportunity for a hearing. If the disciplinary panel determines that there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of [the OAH] followed by an exceptions process before a disciplinary panel; and if a disciplinary panel determines there is no genuine dispute as to a material fact, [the Respondent] shall be given a show cause hearing before a disciplinary panel; and it is further

ORDERED that, after the appropriate hearing, if the disciplinary panel determines that [the Respondent] has failed to comply with any term or condition of this order, the disciplinary panel may reprimand [the Respondent], place [the Respondent] on further probation with appropriate terms and conditions, or revoke [the Respondent's] license to practice medicine in Maryland. The

disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon him; and it is further

ORDERED that a violation of probation or of a permanent condition constitutes a failure to comply with a term or condition of this order[.]

Specifically, the State contends that the Respondent used [redacted] though he was prohibited from doing so by his PRA; failed to cooperate with the comprehensive evaluation requested by the MPRP; and failed to respond to MPRP directives requesting a signed ROI and a return phone call regarding the evaluation. The Respondent adamantly denied violating his PRA by using [redacted] While he did not dispute that the requested evaluation never took place, that he submitted the ROI late, or that he failed to contact the MPRP when requested to do so, he essentially contended that these events flowed from the MPRP's unreasonable, unfair, and unscientific handling of his first positive toxicology test.

When not otherwise provided by statute or regulation, the standard of proof in a contested case hearing before the OAH is a preponderance of the evidence, and the burden of proof rests on the party making an assertion or a claim. State Gov't § 10-217; COMAR 28.02.01.21K. To prove an assertion or a claim by a preponderance of the evidence means to show that it is "more likely so than not so" when all the evidence is considered. *Coleman v. Anne Arundel Cnty. Police Dep't*, 369 Md. 108, 125 n.16 (2002). The State bears the burden to establish the alleged violations by a preponderance of the evidence. Health Occ. § 14-405(b)(2); COMAR 28.02.01.21K(1)-(2)(a). Based on the evidence presented, I find that the State has met this burden, the Respondent's license is subject to revocation, and that revocation is the appropriate sanction.

Analysis

The Respondent Used [redacted] in Violation of the PRA and PRP with the MPRP

The State presented evidence of two separate positive toxicology results: a positive test for [redacted] in a blood sample from September 4, 2024 (followed up by a confirmatory test), and a positive test for [redacted] in a urine sample from November 8, 2024. The Respondent vehemently denied any use of [redacted] and he presented an array of arguments to support his contention that the State failed to show, by way of reliable toxicology results, that he used [redacted] Specifically, he argued that: (1) it would make no sense for him, after nearly five years of negative toxicology tests, to use [redacted] just before his final toxicology test; (2) contamination of the samples, either by those handling them or inadvertently by the Respondent himself, is a reasonable and more likely alternative explanation for the positive results; (3) alleged delays in processing the test results undermine their reliability; (4) the DBS test used is prone to false positives; (5) no reliable confirmation tests were performed to verify either test result; (6) the State's experts contradicted one another, undermining the reliability of their testimony; and (7) the State failed to show that the Respondent intentionally and knowingly used [redacted] rather than accidentally ingesting it.

I have carefully considered these arguments, and I have weighed them against the toxicology results and expert testimony submitted by the State. Importantly, my decision cannot turn on the *possibility* of some alternative explanation for the positive toxicology results; rather, I must consider whether the evidence shows that *it is more likely than not* that the Respondent used [redacted] While the Respondent's arguments raise possible alternative explanations, I found none of them sufficiently supported or compelling to persuade me that they are more likely than the simple, evidence-supported explanation that the Respondent deliberately

used [redacted] I am also not persuaded that his denial regarding the use of [redacted] is truthful. I detail my reasoning below.

The Irrationality of an Act is Not Persuasive Evidence It Did Not Occur and the Respondent's Denial is Not Credible

The Respondent maintained that after nearly five years of consistently negative tests, it would have been "ridiculous" for him to "sabotage" himself by using [redacted] just before his final toxicology test – a test that he knew would take place around September 4, 2024. He noted that he would have no motive to do such a thing. However, that self-sabotage is arguably both irrational and regretful does not, unfortunately, establish that it did not occur. Notably, the alleged absurdity of an act is not evidence; rather, it relies on the premise that people are unlikely to engage in actions that are contrary to their own interests. Such a premise, while clearly sensible, comports with neither the reality of human behavior nor with the Respondent's own history of substance use.[23] People do in fact commit acts that cause them harm, for countless reasons, including impulsivity, emotional distress, poor judgment, overconfidence, and chemical or psychological dependence on illicit substances.

Further, Dr [redacted], whom I accepted as an expert in addiction medicine, credibly testified that it is not unusual for a person to abstain from substance use for several years, only to relapse despite having successfully maintained an extended period of abstinence. In short, the irrationality of using [redacted] just before the last toxicology test administered during a probationary period has virtually no weight in an analysis of whether such use occurred, particularly when weighed against documented positive toxicology results.

[23] The record documents the Respondent's prior positive test result for [redacted] *See* State Exs. 6 & 7.

In arguing that it would be irrational for him to use [redacted] just before his final toxicology test, the Respondent also seeks to bolster the veracity of his denial. The Respondent testified at length, and generally, I found his testimony both frank and forthcoming. He explained that he had been prescribed [redacted] while he was a student in 2013 but did not need it to function well in his professional or family life. He acknowledged that [redacted] is present in his home, as both [redacted] are prescribed the medication by their respective physicians. He detailed the course of his probation, testifying that while he was initially reluctant to submit to toxicology tests, he ultimately understood that it was necessary if he wanted to practice medicine. The Respondent stated that he knew he was to have a test around the Labor Day weekend in 2024, so he quickly complied when he was told he should complete the test on September 4, 2024. From the moment he was first informed of the positive test result from the September 4, 2024 blood sample, he has adamantly denied using [redacted]

However, the Respondent's denial simply cannot be reconciled with the objective reality of the positive DBS test result, which reflects not a trace amount, but a level of [redacted] consistent with a therapeutic dose. As I discuss below, there is no other compelling, evidence-based explanation for the positive toxicology test other than the Respondent's deliberate use of the medication. The Respondent's denial, while vehement, is also entirely in his own self-interest. The Respondent's professional license to practice medicine is at stake. The serious consequences of using [redacted] in violation of the conditions of probation are such that even a person with a tendency to be truthful might reflexively deny such a violation. That the Respondent had a positive urinalysis test two months (November 2024) later further undermines the credibility of his denial.

The Evidence Does Not Support a Finding That Sample Contamination Occurred

The Respondent's arguments regarding contamination are twofold: first, that the sample

collection process or subsequent handling of the samples by the testing facilities could have caused their contamination, and/or that incidental exposure due to the Respondent's handling or accidental ingestion of his [redacted] medication could have caused the positive results. I conclude that these arguments are not supported by any reliable evidence. In so finding, I give significant weight to the testimony of the MROs who testified on behalf of the State, Dr. [redacted] and Dr [redacted]. Dr. [redacted] explained that MROs are licensed medical doctors with special training in toxicology. Their job includes contacting donors with positive toxicology results to conduct an interview. They can then provide an independent, unbiased interpretation of the validity of toxicology results in the context of that additional information.

I first address the DBS test result from the September 4, 2024 sample. This test was resulted by OpAns, LLC, of which the MPRP is a client. Dr. [redacted], a certified MRO, is the Medical Director of OpAns. Dr. [redacted] explained that he reviewed the positive test result from the September 4, 2024 sample. Regarding collection of the sample, Dr. [redacted] testified in detail about the specific steps while demonstrating the process with a kit used to collect such samples. He held up the trifold card where the individual being tested places blood spots, as well as the lancet, gauze, and FedEx envelope for mailing the sample to the lab. He further explained how a bar code is used to track the identity of the donor and ensure that samples are accurately matched to their donors. He also explained how the sample is handled to ensure its integrity once it is received by the lab. Finally, Dr. [redacted] testified that the laboratory is subject to inspections and audits by its certifying bodies, and is authorized to conduct testing in clinical trials, subjecting it to additional inspections.

Dr. [redacted] testimony made clear that it was extremely unlikely that the September 4, 2024 sample was contaminated during the collection process. He explained that the collection is proctored by video, which is recorded, and that collection must be completed in a single

sitting. The kit includes a blue pad for the individual to place on the surface of the table in front of him to create a sanitized barrier. With a checklist in hand, the proctor observes the entire collection process to ensure compliance with the procedures and the integrity of the collection process. The Respondent presented no evidence that either a flawed collection process or errors in the lab's subsequent handling of the sample introduced any kind of contaminant.

I am also not persuaded that the positive result could have been due to the Respondent's handling of [redacted] patch or liquid medication. Dr. [redacted] credibly testified that the collection process includes instructions to ensure that the individual's hands are clean when the sample is collected through a finger prick, and that if these instructions are followed, a sample should not be contaminated by a substance on the skin. In fact, he stated that there would be "zero likelihood" of contamination. But more significantly, Dr. [redacted] noted that the amount of [redacted] reflected in the result – 24.3 ng/mL – is a therapeutic level of [redacted] This amount of [redacted] is too **high to be explained by incidental contact** with [redacted] patch or even accidental ingestion of any residue from a juice bottle used to give [redacted] liquid medication. The record shows that Dr. [redacted] discussed such incidental contact with the Respondent on September 13, 2024, when he called to inform the Respondent of the positive test result.[24] At that time, Dr. [redacted] told the Respondent that "residual or briefly touching" a patch would not result in the amount of [redacted] measured, and the Respondent agreed.

In his testimony, the Respondent agreed that contact with liquid residue was a very unlikely explanation for the level of [redacted] in **the sample. However, he maintained that contact** with [redacted] patch was a possible explanation. The Respondent testified that [redacted] patch is placed on [redacted] hip, and that he would remove the patch at mealtimes to mitigate the medication's effect on [redacted] appetite. To preserve the patch's adhesion for

[24] State Ex. 11, p. 137.

reapplication, he would press it to the back of his driver's license. Doing this repeatedly, he explained, has left a residue on his driver's license. Because of the brevity of his contact with the patch, especially in the context of a busy family life and meals at restaurants, the Respondent did not take precautions such as using gloves to handle it. The Respondent contended that he could have had medication residue on his finger at the time of the September 4, 2024 finger prick, and that it would take only a small amount of residue to contaminate the sample. The Respondent maintained that one of the blood spots from the DBS test should have been tested for the [redacted] meaning the product of the body's metabolization, because a sample that was negative for the [redacted] but positive for the "parent" substance [redacted] would likely have been contaminated by medication on the finger, as evidence of ingestion was lacking.[25]

The Respondent's arguments are not persuasive. First, Dr. [redacted] testified that the blood sample collection process includes three separate instances of cleaning/sanitizing. As a licensed physician, the Respondent is certainly aware of the importance of complying with cleaning and sanitizing the skin to avoid both infection and contamination. There is no basis for concluding that his ability to understand and comply with the explicit instructions for cleaning/sanitizing was in any way compromised, or that the proctor failed to ensure such compliance. Second, Dr. [redacted] credibly testified that even repetitive contact with a [redacted] patch would not result in a [redacted] level as high as 24.3 ng/mL.

Finally, Dr. [redacted] expert testimony also refuted the Respondent's contentions regarding testing for [redacted] Dr. [redacted] explained that a blood sample would not be a reliable body fluid for evaluating the presence of [redacted] as the

[25] The Respondent appears to have first made this request in a letter he sent to the Board on November 25, 2024, which was after his discharge from the MPRP.

blood would contain only very small amounts of the [redacted] and these amounts would be moving through the body's entire bloodstream. Further, while the testing method is very sensitive to small amounts of a substance, [redacted] has a short half-life, so levels drop quickly. Thus, the small amount of [redacted] present in the bloodstream would fall rapidly, quickly reducing its concentration and making its detection in a blood sample difficult. While testing a blood sample for [redacted] might be useful in some cases for ruling out possible contamination as the reason for a positive [redacted] result, Dr. [redacted] had already effectively ruled out contamination as a credible explanation because of the high level of [redacted] detected in the Respondent's blood – a level that exceeded what could reasonably be attributed to contamination.

Regarding the November 8, 2024 urine sample, the State offered the testimony of certified MRO Dr. [redacted], Medical Director of Affinity Online Solutions, which resulted the positive urinalysis. He testified that his first involvement in the Respondent's case occurred in December 2024, when Ms. Thrasher asked him to interpret the positive urinalysis result. By that time, the Respondent had already been discharged from the MPRP, so Dr. [redacted] did not contact him to discuss the positive result. However, it was his opinion that the urinalysis result meant that the Respondent had "ingested" [redacted] in the one to four days prior to the test.[26] Like Dr. [redacted] Dr. [redacted] described the chain-of-custody and lab procedures used in handling samples. He noted that samples that test positive in the initial screening are then subject to confirmatory testing to rule out false positives. In this case, the confirmatory result was 113 ng/mL. Because the test was for the [redacted] it was Dr. [redacted] expert opinion that this result reflected ingestion of [redacted] He explained that the term "ingested" could refer to

[26] State Ex. 17, p. 178.

absorption by the body after the substance is consumed orally or through the skin; the test result itself would not reveal how the substance was "ingested," only that it was.

While Dr [redacted] agreed that 113 ng/mL was a low level of the [redacted] he declined to confirm the Respondent's theory that handling [redacted] patch might allow for sufficient absorption for his body to produce this level of [redacted] He opined that it might be possible, but that he had never seen any studies that would support such a theory. Additionally, he expressed the opinion that a responsible, medically trained person undergoing regular probationary toxicology testing would take precautions to minimize any exposure through contact with a [redacted] patch. This skepticism of the Respondent's claim is consistent with Dr. [redacted] testimony that while he reviewed the Respondent's December 13, 2024 written response to the positive test (and subsequently produced a written report[27]), he did not find the Respondent's denial of ingestion to have any "validity," though he did not specifically conclude that such ingestion was necessarily intentional.

Nonethless, there was no evidence that the urine sample tested positive due to any lapses in the chain of custody or lab procedures that might have contaminated the sample. Further, while it strains credibility that handling [redacted] patch or accidentally consuming the residue of [redacted] liquid medication resulted in the positive blood test, that theory is even less plausible with regard to the November 8, 2024 urinalysis result because by the time that sample was taken, the Respondent had already identified such incidental contact as potentially problematic. The Respondent articulated this explanation in a letter to the Board dated September 30, 2024; he testified that he continued to check his portal to comply with any additional requested toxicology tests through mid-November 2024. If the Respondent truly believed that incidental exposure to [redacted] was a potential explanation for a

[27] State Ex. 24.

September DBS test result he claimed to be a false positive, it would frankly be astonishing that he would blithely continue any contact that risked such exposure after learning of that test result. I find it so astonishing, in fact, that it severely undercuts his explanation that either of the positive results could be explained by such contact; it is clear that the Respondent himself did not believe that explanation for the first positive result, or he would not have been in a position to argue it regarding the second because he would have taken precautions.[28]

Alleged Time Delays in Processing Samples Did Not Compromise Their Accuracy

The Respondent also challenged the validity of the November 8, 2024 urine test based on the lapse of time between the sample collection, the lab's receipt of the sample on November 13, 2024, and the November 27, 2024 report reflecting the positive result. The State noted that the sample was collected on a Friday and received at the lab the following Wednesday; the report was dated two weeks later. In his testimony, Dr. [redacted] stated that this was not an atypical timeline for processing the sample and reporting the test result, and that if slower processing had any impact at all, it would be to make it more difficult to detect a substance; it would not amplify a result.

The Respondent was then notified of the result by letter from the Board, which was dated twelve days after the November 27, 2024 report date. During the intervening time, the Respondent was not contacted by Dr. [redacted] or the MPRP, and thus he did not have an opportunity to explain or challenge the result before it was reported to the Board. Ms. Thrasher explained that by that time the MPRP received the result, the Respondent had already been

[28] The Respondent was provided a toxicology protocol stating that precautions to avoid false positives were his responsibility and that a single positive result could be a basis for sanctions. (State Ex. 28g.)

discharged from the program, so there would have been no point to discussing the result with the Respondent.

It is understandable that the Respondent was surprised and dismayed to receive the urinalysis test results from a November 8, 2024 sample nearly a month later. However, the Respondent presented no evidence that this had any impact on the integrity of the sample or the validity of the test result. He implied that the timing and the MPRP's decision not to involve an MRO before reporting the result to the Board somehow generates an inference that the MPRP had nefarious intent. The Respondent provided no evidence of such intent; to the contrary, the record reflects repeated attempts by the MPRP to work with the Respondent, including attempting to schedule the hair test he requested (State Ex. 28m), providing him with a virtual option for an evaluation (State Ex. 28p), and extending the deadline for his submission of the ROI (State Ex. 28q). Accordingly, the timeframe for handling the November 8, 2024 urinalysis has no impact on my analysis.

DBS Test Was Not Shown to Be Prone to False Positives or Noncompliant With Federal Law

The Respondent argued that the DBS test is unreliable, citing Adverse Event Reports submitted to the Food and Drug Administration (FDA). The Respondent submitted five such reports into evidence, four of which were submitted by individuals who identified themselves as patients.[29] (The fifth report appears to be the Respondent's own report to the FDA, as it matches the facts of his case.[30]) Generally, these reports complain about positive DBS test results they allege to be false, and the impact of positive tests on child custody matters, situations involving child protective services, and drug court probationary requirements. These reports are

[29] Resp. Exs. 1 through 4.
[30] Resp. Ex. 5.

anonymous submissions and include no indications that they have been acknowledged, reviewed, investigated, or verified by the FDA. As the reports are unverified allegations by anonymous individuals, I cannot evaluate either the basis for or the reliability of the claims, and I therefore give them no weight.

The Respondent also alleged that neither the DBS test collection device nor the confirmation testing that utilizes it[31] are FDA-approved. Dr. [redacted] did not dispute this; he testified that components of the DBS card, such as the paper, are FDA approved, though the tri-fold card itself is not, as such approval is not necessary. Dr. [redacted] also testified that confirmation tests, unlike screening tests, do not generally require FDA approval.

The Respondent identified no specific federal statute, regulation, guidance documents, or other policies that contradict Dr. [redacted] testimony on this point. The Respondent also provided no evidence that OpAns, LLC, or the manufacturer of the devices and tests it uses, have been found noncompliant with, charged with, or found in violation of any provision of the Food and Drug Act or its implementing regulations. In light of Dr. [redacted] expertise as an MRO, including many years of experience, I find his testimony both highly credible and uncontradicted, and I give it great weight in concluding that there is no meaningful support in this record for treating the DBS test result as unreliable based on a flawed collection device or the fact that it is not approved by the FDA.

That Subsequent Confirmation Tests Were Not Performed Does Not Cast Doubt on the Positive Test Results

The Respondent contended that because valid confirmation tests to verify the positive toxicology results were not performed, the positive results, which followed years of consistently

[31] Dr. [redacted] identified Agilent as the brand-name of the confirmation test performed.

negative tests, should therefore be considered aberrations and are thus unreliable. The Respondent acknowledged that the initial DBS test was followed up with a second test on one of the other three blood spot samples he had provided on the card but contended that these three spots were effectively the same sample, as all three were produced from a single finger prick. He argued that the DBS test should have been confirmed with additional science-based, quantitative testing of another modality, such as a hair **test.**

The Respondent's concern about using same finger prick for all three blood spots is rooted in his speculation that contamination, such as the presence of [redacted] on the skin of his finger, may have led to the positive DBS test result. He reasoned that skin contamination would likely affect all three blood spots, dismissing Dr. [redacted] testimony that if a skin contaminant was present, it would most likely affect the first spot of blood provided, but probably not the other two. I agree that Dr. [redacted] testimony was not particularly persuasive on this point, as it did not appear to be an issue he had encountered before, and he seemed to be reluctantly offering his best guess. However, as discussed above, I am not persuaded that skin contamination is reasonably considered a factor in my analysis, as the individual collecting the sample is instructed to wash and sanitize his hands repeatedly, and to use an alcohol swab to clean the skin as a proctor observes by video.

As contamination is not an issue, I find no support in this record for treating the subsequent test performed at the Respondent's request and using another of the blood spots collected on September 4 as unreliable. Dr. [redacted] explained that the subsequent test, performed on or about September 18, 2024, did not produce a quantitative result because by then, some deterioration of the sample collected on September 4 had occurred. Dr. [redacted] further testified that as [redacted] was detected by the second test, it was properly considered to

have confirmed the prior test result despite the absence of a quantitative result. I find no basis in this record to doubt Dr. [redacted] expert testimony on this point.

The Respondent testified that after the positive result from the September 4 sample, he requested that a hair analysis be performed. He explained that he sought this analysis to show there had been no chronic use of [redacted] which would support his contention that the positive DBS test was aberrant and thus likely a false positive. Ms. Thrasher testified that the MPRP was willing to accommodate the Respondent's request for a hair test and worked with him to schedule it but then learned that analysis for [redacted] was not available with the provider with whom they had scheduled the evaluation. The Respondent attempted to locate a provider who could perform the analysis but testified that he felt the MPRP instead steered him towards an evaluation that he believed would not be necessary if the hair analysis he was requesting could be done.

It is not clear why the requested hair analysis never occurred, and the Respondent's frustration regarding the test is understandable. Mr. Whigham acknowledged that the Respondent had hair analysis performed at an earlier point in his probationary period. Additionally, both Drs [redacted] and [redacted] stated that hair analysis was available through the labs employing them, though Dr. [redacted] explained that OpAns did not conduct such analyses in-house. Ms. Thrasher did not provide a cogent explanation for the MPRP's apparent sidelining of this request in favor of the Respondent undergoing an evaluation instead.

However, Dr. [redacted] testified that a hair test would have been "without value" in this case anyway, because a negative hair test is not reliable evidence of abstinence and would not negate a positive toxicology test. No expert testimony refuted his opinion on this point, and I give it significant weight. Accordingly, that a hair analysis was not performed does not alter my conclusion that the evidence shows that the Respondent likely used [redacted]

Additionally, and more importantly, it is not at all clear that a negative hair test would have changed the MPRP's position that an evaluation was necessary, despite the Respondent's apparent assumption that it would or should. In fact, even as the Respondent and Ms. Thrasher discussed the possibility of hair analysis by email, she was simultaneously explaining to him the importance of moving forward with the evaluation.[32] Ms. Thrasher further testified that while an evaluation was initially requested because of the positive test result, the Respondent's difficult and combative behavior further convinced the MPRP of the necessity of such a comprehensive evaluation. Importantly, the Respondent was not discharged by the MPRP because he had a positive toxicology test and was unable to obtain hair analysis to refute it, but because he failed to follow through with the next steps the MPRP required, even though those steps may very well have been required regardless of any hair analysis results.

Relatedly, the Respondent also argued that neither Dr. [redacted] nor Dr. [redacted] were able to state the rate of false positives from their facilities, and that this means that they gave insufficient credence to the possibility that test results such as the Respondent's were falsely positive. However, both Dr. [redacted] and Dr. [redacted] provided clear, cogent explanations as to why the positive toxicology tests were extremely unlikely to be false positives; I found their explanations highly credible. Dr. [redacted] testified that the urine sample underwent an initial screening, and that the screening can produce both false positives and false negatives. Accordingly, positive screening results are then subjected to confirmatory testing. This testing provides what he termed a "fingerprint" of the substance at issue that is specific to that substance, and it quantifies the amount of the substance detected. It can also refute a falsely positive screening test. When questioned about false positives on the confirmatory test,

[32] State Exs. 28m & 28n.

Dr. [redacted] said that in his many years of doing this kind of work, he has never seen what he deemed to be a false positive.

Similarly, Dr. [redacted] testified that the DBS sample is tested for the specific substance; in fact, samples do not even go through an initial screening process intended to flag samples for further testing. Instead, samples are subjected to only to confirmatory testing using liquid chromatography mass spectrometry, which he testified to be highly accurate: "the gold standard" for confirmatory testing, according to Dr. [redacted]. Dr. [redacted] credibly explained that the methodology means that cross reactivity (a falsely positive result caused by a similar chemical substance) does not occur. In light of their expertise, as well as the clarity and reasonableness of their explanations, I found the testimony of Drs. [redacted] and [redacted] regarding false positives highly persuasive, effectively ruling out the possibility of such errors.

The Testimony of the State's Expert Witnesses Was Not Contradictory on Any Material Matter

The Respondent argued that Drs. [redacted] and [redacted] contradicted one another. He cited what Dr. [redacted] characterized as a "relatively low" urinalysis result for [redacted] of 113 ng/mL, while Dr [redacted] testified that the amount of [redacted] (24.3 ng/mL) would have required ingesting a "large amount" of [redacted] However, the Respondent did not persuasively identify any contradiction. It is true that Dr [redacted] explained that his conclusion that the Respondent had "ingested" [redacted] was not specific regarding the method of ingestion, which could be either oral or through the skin. Dr. [redacted] testimony more clearly rejected the possibility that skin absorption could explain it. But these toxicology tests were of different modalities, used different body fluids, measured for different substances, used samples collected over nine weeks apart, and differed significantly regarding the relative level of the substance measured. It is logical to conclude that the higher relative result – a therapeutic level of [redacted] – is far less compatible with the explanation that exposure occurred

through incidental skin contact, such as handling [redacted] patch. Accordingly, I find no contradiction in the testimony of these experts that compromises their credibility.

There Is No Persuasive Evidence of Accidental Ingestion as a Plausible Alternative to Deliberate, Knowing Use of [redacted]

The Respondent maintains that accidental ingestion of [redacted] could explain the toxicology results, and that while there is no technical requirement of intentionality for a probationary violation, the prohibited use of [redacted] contemplated by the Order is presumably deliberate use. This argument appears to be distinct from the Respondent's argument regarding minor, incidental exposure, such as touching a patch, pill, or juice bottle bearing the residue of liquid medication, which I have addressed above.

Certainly, imagination can conjure numerous scenarios where accidental ingestion might occur, resulting in the relatively high level of [redacted] measured in the DBS test. The Respondent testified that during the relevant time, not only was [redacted] prescribed [redacted] but [redacted] was also prescribed [redacted] in pill form. The presence of the medication in the Respondent's home could lead to a mix-up, where the Respondent accidentally took [redacted] medication instead of an over-the-counter medication he intended to take, or where he mistakenly consumed a drink containing medication that [redacted] prepared for [redacted]. Someone could have maliciously put the medication in the Respondent's food or drink without his knowledge. However, the Respondent neither argued nor presented evidence of any such scenario having actually occurred. He made no specific allegation; he only speculated that his unknowing ingestion was possible. The vagueness of the Respondent's contention that perhaps accidental ingestion could explain the positive test result renders it entirely unconvincing.

In short, none of the arguments offered by the Respondent are sufficiently persuasive or supported to undermine the validity of the toxicology results, and the Respondent's denial is not

credible. For these reasons, I conclude that he used [redacted] in violation of the PRA and PRP, and in so doing, violated the terms of the August 16, 2019 Order of Reinstatement with Conditions.

The Respondent Did Not Comply With All Evaluations as Directed by the MPRP

That the Respondent did not comply with the evaluation requested by the MPRP is not in dispute. He acknowledged that he was resistant to the request because he questioned the positive toxicology result, did not feel that the MPRP had agreed to meaningful scientific confirmation of it. Additionally, he objected to the proposed evaluations because their costs and logistics were unduly burdensome.

Regarding the former, while it is understandable that the Respondent wanted confirmation of positive results he maintained were false, the terms of his probation do not allow for such a demand in lieu of the requested evaluation. The language of the Order is clear and explicit: the Respondent "shall fully participate and comply with all therapy, treatment, testing, and evaluations as directed by MPRP[.]"[33] Similarly, the PRA requires that the Respondent "obtain any medical, neurological, or psychological/substance abuse evaluations" recommended by the MPRP.[34] It is undisputed that that such participation and compliance did not occur, and that this was because the Respondent failed to follow through with a scheduled evaluation.

Regarding the latter, the record makes clear that the MPRP accommodated the Respondent's concerns about cost and logistics. Ms. Thrasher testified that MPRP first proposed a comprehensive in-person evaluation at the University of Florida, which would include a polygraph to evaluate whether the Respondent had used [redacted] The Respondent initially agreed but then changed his mind, explaining that the cost and his family's

[33] State Ex. 8.
[34] State Ex. 28g.

circumstances meant that travel to Florida was just not a feasible option for him.[35] Ms. Thrasher subsequently identified an evaluator in Chicago, but this posed similar challenges for the Respondent.

Ultimately, by email on October 24, 2024, Ms. Thrasher directed the Respondent to schedule with a provider (All Points North) who was available for a virtual (online) evaluation. The Respondent's late submission of the required release form delayed the effort to schedule the evaluation, and then once scheduled, the Respondent requested that it be rescheduled to a week later (November 18, 2024). When the Respondent became unresponsive to the provider's request for completion and submission of pre-admission paperwork, the November 18, 2024 evaluation was cancelled. The Respondent's concerns regarding cost and logistics do not mitigate his failure to comply with the directive that he undergo an evaluation, as the MPRP clearly accommodated those concerns by arranging for a virtual evaluation.

The Respondent's objection to the polygraph does not permit me to make a contrary finding. The Respondent testified to his frustration with inclusion of the polygraph, noting that such tests can be expensive and are often given repeatedly. He also explained that he felt harassed and disrespected by the request, as polygraphs are of dubious scientific value. His testimony made clear that more broadly, he felt that the evaluation process meant shifting him from an objective, scientific toxicology-test approach to a subjective, unscientific approach where he would be unfairly treated as a drug addict. The Respondent further felt that his case should not be handled by psychologists or social workers but by a forensic psychiatrist, with medical training.

I am sympathetic to the Respondent's objections and recognize that as a trained and experienced medical doctor, he was reasonably discomfited by the prospect of an evaluation that

[35] State Ex. 28o.

included a polygraph test and providers without medical training. However, the Board ordered that the Respondent enroll in the MPRP and comply with all testing and evaluations as directed by the MPRP. I am not tasked with determining the soundness of the MPRP's directives regarding testing and evaluations; to do so would be outside the scope of my delegated role. The issue before me is only whether the Board has shown that the Respondent failed to comply with an evaluation requested by the MPRP, and the evidence supports a conclusion that the Board has shown such a failure to comply.

The Respondent Did Not Timely Submit the ROI or Contact the MPRP, as Directed by the MPRP

Again, the facts regarding the untimely submission of the ROI and the Respondent's failure to return Ms. Thrasher's phone call, in which she directed him to contact the MPRP, are not in dispute. The Respondent did not deny that he was frustrated, stressed, and resistant to complying with the evaluation, and that his unwillingness to cooperate was the reason for his late submission of the ROI and his subsequent unresponsiveness regarding the evaluation. He acknowledged that, consistent with Ms. Thrasher's testimony, he nonetheless continued to engage with the MPRP portal because he had not been instructed to stop doing so, and he did not want to miss any required toxicology tests. The Respondent did dispute Ms. Thrasher's characterization of him as hostile and rude to staff at MPRP and All Points North, explaining that he felt staff was dismissive of his request to talk to a scientist and became antagonistic with him when he insisted on that. He further testified that he did not feel he was being listened to or understood.

The Order explicitly requires that the Respondent sign any written release/consent forms. It also states that he must comply with all MPRP "referrals, rules, and requirements." While I do not doubt the genuineness of the Respondent's frustration, the facts nonetheless compel me to

find that he failed to comply with MPRP directives requesting that he submit the ROI and to contact the MPRP when instructed to do so. These actions constitute a violation of the Order.

Sanctions

In this case, the State seeks to impose the disciplinary sanction of revocation, citing the Respondent's lengthy disciplinary history, which dates back to 2006. Health Occ. § 14-404(a); COMAR 10.32.02.09A & B; COMAR 10.32.02.10. The State emphasizes that when a positive toxicology result was documented in September 2024, the Respondent challenged the process that followed, despite having agreed to the PRA and being subject to the Order. In challenging the process, the Respondent became increasingly uncooperative, unprofessional, and ultimately, unresponsive. The State further argues that the Respondent's disciplinary record as a whole demonstrates a failure to conduct himself with respect and dignity, and to consistently maintain the professionalism required of a licensed physician.

Revocation is a severe consequence. However, the Board's mandate is "to protect the health, safety, and welfare of the public"; ensuring such protection requires that it exercise appropriate disciplinary action. Health Occ. § 1-102(a) (2021).

The Respondent is correct that over the five-year probationary period, he had literally hundreds of negative toxicology tests. That his very last toxicology test was positive is understandably distressing to him. However, when the Respondent learned of the positive toxicology test, he could have fully cooperated with the MPRP's requirements by following through with the requested comprehensive evaluation, despite his frustration and misgivings with that process. MPRP clearly demonstrated that it was responsive to the concerns he expressed about expensive, out-of-state evaluations. Instead of adhering to the terms of his probation, the Respondent doubled down on his insistence that the positive result had to be false and refused to

participate in the evaluation and to follow MPRP directives. His response effectively foreclosed the viability of lesser sanctions, such as extending the period of probation.

Accordingly, I conclude that the Respondent's disciplinary history, the nature of the violations for which his license was previously revoked prior to this reinstatement with conditions, and the Respondent's persistent non-cooperation with the MPRP and the terms of the Order, render revocation an appropriate disciplinary action.

PROPOSED CONCLUSIONS OF LAW

Based on the Proposed Findings of Fact and Discussion, I conclude as a matter of law that the Respondent violated the Order of Reinstatement With Conditions issued on August 16, 2019. As a result, I conclude that the Respondent is subject to disciplinary sanctions. Md. Code Ann., Health Occ. § 14-404(a).

I further conclude that, upon consideration of the State's interest in protecting the health, safety, and welfare of the public and the regulatory guidelines and factors, the appropriate sanction is revocation. *Id.*; COMAR 10.32.02.09A, B; COMAR 10.32.02.10A; B(3)(e), B(4), & B(27).

PROPOSED DISPOSITION

I **PROPOSE** that charges filed by the Maryland Board of Physicians against the Respondent on March 3, 2025, be **UPHELD,** the Respondent be found to have violated the

August 16, 2019 Order of Reinstatement With Conditions issued by the Maryland Board of Physicians;

I **PROPOSE** that the Respondent be sanctioned **by revocation.**

Signature on File

January 14, 2026
Date Decision Issued

Jennifer L. Gresock
Administrative Law Judge

JLG/sss
#222288

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party adversely affected by this proposed decision may file written exceptions with the disciplinary panel of the Maryland Board of Physicians that delegated the captioned case to the Office of Administrative Hearings (OAH) and request a hearing on the exceptions. Md. Code Ann., State Gov't § 10-216(a) (2021); COMAR 10.32.02.05. Exceptions must be filed within fifteen (15) days of the date of issuance of this proposed order. COMAR 10.32.02.05B(1). The exceptions and request for hearing must be addressed to the Disciplinary Panel of the Board of Physicians, 4201 Patterson Avenue, Baltimore, MD, 21215-2299, Attn: Christine A. Farrelly, Executive Director.

A copy of the exceptions should be mailed to the opposing attorney, and the other party will have fifteen (15) days from the filing of exceptions to file a written response addressed as above. *Id.* The disciplinary panel will issue a final order following the exceptions hearing or other formal panel proceedings. Md. Code Ann., State Gov't §§ 10-216, 10-221 (2021); COMAR 10.32.02.05C.

The Office of Administrative Hearings is not a party to any review process.

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MARYLAND STATE BOARD OF	*	**BEFORE JENNIFER L. GRESOCK,**
PHYSICIANS	*	**AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE**
ERIC GREENBERG, M.D.,	*	**OF ADMINISTRATIVE HEARINGS**
RESPONDENT	*	
LICENSE No.: D50275	*	**OAH No.: MDH-MBP2-71-25-14149**

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

APPENDIX

I admitted the following exhibits into evidence on behalf of the State:

State Ex. 1	Respondent's MBP Profile, printed January 30, 2025
State Ex. 2	Consent Order, dated May 24, 2006
State Ex. 3	Termination of Probation Order, dated August 3, 2006
State Ex. 4	Consent Order, dated June 27, 2007
State Ex. 5	Order of Summary Suspension of License to Practice Medicine, dated April 16, 2009
State Ex. 6	Final Decision and Order, dated May 19, 2011
State Ex. 7	Decision and Order on Application for Reinstatement, dated May 18, 2016
State Ex. 8	Order of Reinstatement with Conditions, dated August 16, 2019
State Ex. 9	Letter from the Board to the Respondent, dated November 18, 2019
State Ex. 10	Advisory Letter from the Board to Respondent, dated May 1, 2020
State Ex. 11	Email from the MPRP to the Board with attachments, dated September 19, 2024
State Ex. 12	Letter from the Board to the Respondent, dated September 23, 2024
State Ex. 13	Respondent's written response to the Board, dated September 30, 2024
State Ex. 14	MPRP Discharge Letter, dated November 19, 2024

State Ex. 15 Email exchange between the Board and the MPRP, dated September 17, 2024, through November 19, 2024

State Ex. 16 Letter from the Board to the Respondent, dated November 20, 2024

State Ex. 17 Email with attachment from the Respondent to the Board, dated November 25, 2024

State Ex. 18 Email exchange with attachments from the MPRP to the Board, dated December 2, 2024

State Ex. 19 Email from the Board to the Respondent, dated December 9, 2024

State Ex. 20 Email from the Respondent to the Board, dated December 17, 2024, with attached letter, dated December 13, 2024

State Ex. 21 Email from Amber Thrasher to the Board with Respondent's MPRP file attached (MPRP file is included on USB drive as State Ex. 28)

State Ex. 22 *Curriculum Vitae* of [redacted], M.D.

State Ex. 23 *Curriculum Vitae* of [redacted] M.D.

State Ex. 24 MRO Report, Dr. [redacted], dated July 30, 2025

State Ex. 25 November 2024 calendar

State Ex. 26 Violation of Order of Reinstatement with Conditions and Notice to Show Cause, filed March 3, 2025

State Ex. 27 NOT OFFERED OR ADMITTED
(Sample Dry-Blood Spot Card Demonstration)[36]

State Ex. 28 Respondent's MPRP File (on USB Drive)

- 28a. Closure Letter, dated November 19, 2024
- 28b. MRO Report, Dr. [redacted] undated
- 28c. Quarterly Demos and Attendance Log, various dates
- 28d. Toxicology Audit, September 5, 2019, through November 15, 2024
- 28e. Evaluation, Dr. Zimnitzky, dated June 12, 2019
- 28f. 14-402 Evaluation documentation, various dates
- 28g. MPRP Participant Rehabilitation Agreement and Plans, various dates
- 28h. Attendance reports, various dates

[36] Dr. [redacted] held up a dry blood spot card and other components of the sample collection kit, demonstrating how a sample is collected. Neither the card nor the kit was offered or admitted.

28i. Case Notes, various dates
28j. Final Toxicology, updated September 19, 2024
28k. Intake documentation, various dates
28l. Quarterly reports, various dates
28m. Email exchange between Ms. Thrasher and the Respondent ("MPRP-September OpAns Follow Ups"), dated September 19 to September 23, 2024
28n. Email exchange between Ms. Thrasher and the Respondent ("MPRP/UF Evaluation"), dated September 27 to October 1, 2024
28o. Email exchange ("MPRP/UF Referral"), dated October 3 to October 16, 2024
28p. Email from Ms. Thrasher to the Respondent ("MPRP-All Points North"), dated October 24, 2024
28q. Email exchange ("APN Follow Up"), dated October 25 to October 31, 2024
28r. Email from Ms. Thrasher to the Respondent ("MPRP/APN Case Closure"), dated November 18, 2024

State Ex. 29 NOT OFFERED OR ADMITTED[37]

I admitted the following exhibits into evidence on behalf of the Respondent:

Resp. Ex. 1 FDA MAUDE Adverse Event Report, dated March 28, 2023

Resp. Ex. 2 FDA MAUDE Adverse Event Report, dated April 28, 2023

Resp. Ex. 3 FDA MAUDE Adverse Event Report, dated December 12, 2023

Resp. Ex. 4 FDA MAUDE Adverse Event Report, dated July 30, 2024

Resp. Ex. 5 FDA MAUDE Adverse Event Report, dated September 13, 2024

Resp. Ex. 6 Letter from the Respondent to the Board, dated September 12, 2024

Resp. Ex. 7 NOT ADMITTED

Resp. Ex. 8 Letter from the Respondent to the Board, undated

Resp. Ex. 9 Letter from the Respondent to the Board, dated September 30, 2024

Resp. Ex. 10 Letter from the Respondent to Ms. Thrasher, dated October 21, 2024

Resp. Ex. 11 Letter from the Respondent to Margaret Kroen, dated October 22, 2024

[37] The State showed the Respondent a letter by sharing it via Webex; it was identified as State Ex. 29, but neither offered nor admitted. The State did not submit a copy of the letter into evidence.

Resp. Ex. 12 Email from Ms. Kroen to the Respondent, dated October 22, 2024

Resp. Ex. 13 Email from Ms. Kroen to the Respondent, dated November 1, 2024

Resp. Ex. 14 Email from George W. Maschke to the Respondent, dated December 23, 2024

Resp. Ex. 15 NOT ADMITTED