IN THE MATTER OF	*	**BEFORE THE**
EDEN M. SANCHEZ, PA-C	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: C04811	*	**Case Number: 2016-0477B**

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CONSENT ORDER

On August 11, 2017, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board"), charged Eden M. Sanchez, PA-C (the "Respondent"), License Number C04811, under the Maryland Physician Assistants Act (the "Act"), Md. Code Ann., Health Occ. II ("Health Occ. II") § 15-314(a) (2014 Repl. Vol. & 2016 Supp.).

The pertinent provisions of the Act provide:

> (a) *Grounds.* -- Subject to the hearing provisions of § 15-315 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum, may reprimand any physician assistant, place any physician assistant on probation, or suspend or revoke a license if the physician assistant:
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> ...
>
> (22) Fails to meet appropriate standards for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this state; [or]
>
> ...
>
> (40) Fails to keep adequate medical records[.]

On November 29, 2017, Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

I. FINDINGS OF FACT

Panel B finds:

I. BACKGROUND

1. The Respondent is a Physician Assistant. The Respondent was initially licensed by the Board on July 24, 2012. The Respondent's license is scheduled to expire on June 30, 2019.

2. At all times relevant to these charges, the Respondent was a physician assistant at a group medical practice in Glen Burnie, Maryland specializing in primary care/internal medicine (Practice A).[1]

3. At all times relevant to these charges, the Respondent's assigned supervising physician was Physician A.

4. On or about November 9, 2015, the Board received an anonymous physician complaint alleging that the Respondent had prescribed Lamotrigine[2] to a patient (Patient 1) at a high starting dosage which allegedly caused a severe rash necessitating hospitalization. The complainant physician had contacted Physician A about the dosage and alleged that Physician A was also "unaware" of dosing norms.

5. As a result, the Board initiated an investigation.

6. On or about January 20, 2016, the Board notified the Respondent of its investigation, requested a written response and subpoenaed Patient 1's medical records.

7. On or about February 8, 2017, the Respondent submitted a written response to the Board in response to the allegations regarding her care and treatment of Patient 1.

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[1] To ensure confidentiality, the names of individuals, patients, and institutions involved in this case are not disclosed in this document.

[2] Used in the treatment of seizures, bipolar disorder, and depression.

8. In furtherance of its investigation, on or about December 1, 2016, the Board subpoenaed an additional nine patient medical records and summaries of care (Patients 2-10) from the Respondent and transmitted the ten records along with the summaries of care, and other relevant records, for a peer review to be conducted by a licensed physician assistant.

9. On or about May 4, 2017, the Board received the peer review report, the results of which are set forth in pertinent part below.

PATIENT-RELATED FINDINGS

The peer reviewer found the following deficiencies:

PATIENT 1

10. Patient 1, a female in her early 30s, began treatment with the Respondent in 2014. Patient 1 had a history of bipolar disorder and attention deficit hyperactivity disorder (ADHD). She had been seen by other providers in Practice A prior to being seen by the Respondent. The Respondent saw Patient 1 on four occasions, the most recent being November 17, 2015 for medication refills for Depakote[3] and Adderall.[4]

11. During the November 2015 appointment, in response to Patient 1's complaints that her current medication made her feel "muted" and her mental health was not being "well controlled," the Respondent ordered Patient 1 to cease taking Depakote[5] and prescribed Lamictal.[6]

12. The Respondent prescribed a 30-day supply of the Lamictal to Patient 1 with 5 refills. The Respondent instructed Patient 1 to take 100mg twice a day.

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[3] The brand name for valproate, Depakote is used in the treatment of seizures and bipolar disorder.
[4] A Schedule II drug used in the treatment of ADHD.
[5] Patient 1 had reported she had stopped taking the Depakote one month prior.
[6] Lamictal is used in the treatment of mood disorders.

13. On or about December 6, 2015, Patient 1 presented to an Emergency Department (ED) at a medical center in Anne Arundel County (Hospital A) complaining of a rash and fever. Patient 1's temperature was 102.2 degrees Fahrenheit and ED medical staff diagnosed her with Stevens-Johnson syndrome,[7] covering 30-39% of her total body surface area. She was transferred to Hospital B (specializing in trauma) for intensive care, where she remained for 10 days.

14. The Food and Drug Administration black box warning on Lamictal includes the warning that the medication can cause serious skin rashes requiring hospitalization and discontinuation of treatment. Nearly all cases of life-threatening rashes caused by Lamictal have occurred 2 to 8 weeks following the initiation of treatment.

15. The recommended initial dose for a patient who had previously been taking Depakote (Valproate) is no more than 25 mg/day. The standard of quality care requires that the dosage should be gradually increased; only reaching a recommended maximum of 100 mg/day after six weeks of a steady escalation regimen.

16. The Respondent failed to prescribe the Lamictal consistent with the standard of quality medical care.

17. The standard of quality care requires that prior to initiation of treatment with Lamictal, the patient should be instructed that a rash or other symptoms of hypersensitivity may herald a serious medical event and that the patient should report any such occurrence to a physician (or health care provider) immediately.

18. The Respondent failed to document that she had instructed Patient 1 consistent with ¶ 17.

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[7] Stevens-Johnson syndrome is a serious disorder of the skin and mucous membranes that is usually a reaction to a medication.

19. The Respondent's conduct outlined above in whole or in part is evidence of her failure to meet the appropriate standards for the delivery of quality medical care in violation of Health Occ. II § 15-314(a)(22) and her failure to adequately document her care in violation of Health Occ. II § 15-314(a)(40).

PATIENT 2

20. Patient 2, a female in her late 30s, was seen by the Respondent for several visits between April 2013 and April 2016. Prior to seeing the Respondent, Patient 2 had been seen by other providers at Practice A, including by Physician A. Patient 2 had a history of bipolar disorder and heroin abuse. Patient 2 was being prescribed several medications including but not limited to alprazolam,[8] Trazadone,[9] Wellbutrin,[10] and Seroquel.[11]

21. On or about June 18, 2013, Patient 2 presented with an abscess on her left shin. The Respondent prescribed doxycycline,[12] advised proper hygiene and advised Patient 2 that if the site worsened she should proceed to an ED for a culture and possible incision and drainage.

22. On July 3, 2013, Patient 2 returned for a follow-up visit. The abscess on her left shin had "green, thick purulent drainage." The Respondent advised proper hygiene; extended the doxycycline prescription for an additional week, prescribed Percocet for pain, and advised her that if her leg did not improve to proceed to an ED for "packing."

23. On or about April 14, 2016, Patient 2 presented with a right forearm abscess, and stated that she had a history of "MRSA."[13] Additionally, she reported a dark yellow vaginal

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[8] A Schedule IV benzodiazepine.
[9] Used as a sedative and anti-depressant.
[10] Antidepressant.
[11] Used in the treatment of schizophrenia, bipolar disorder, and depression.
[12] An antibiotic.
[13] Methicillin-resistant Staphylococcus aureus.

discharge and reported to the Respondent she had had unprotected sexual intercourse with her boyfriend who she "thinks" may have had "gonorrhea." The Respondent prescribed doxycycline, mupirocin ointment for the abscess, and provided her with a requisition for an "STD panel."[14]

24. The Respondent's treatment plan for the skin abscesses failed to meet the standard of quality care. The standard of quality care required the Respondent to either perform an Incision and Drainage to drain the abscess or to timely refer Patient 2 to a surgeon or the ED.

25. The Respondent did not conduct a pelvic examination nor did she refer Patient 2 to a gynecologist for evaluation and possible treatment of her vaginal discharge, which would have been consistent with the standard of quality care.

26. The Respondent's actions and inactions outlined in pertinent part above in whole or in part support evidence of the Respondent's failure to meet the standard of quality medical care in violation of Health Occ. II § 15-314(a)(22).

PATIENT 3

27. Patient 3, a female in her early 30s, was initially treated by the Respondent on January 9, 2015. She had recently been released from incarceration, and had a history of anxiety, depression and tobacco use. Patient 3 reported she had been on Seroquel and Depakote in the past. The Respondent did not document that the Respondent was bipolar or had any psychotic disorders. The Respondent did not conduct and/or document a mental status evaluation. The Respondent prescribed antipsychotic medications, referred her to a psychiatry consultation and ordered laboratory studies.

[14] STD stands for Sexually Transmitted Disease.

28. On January 22, 2015, Patient 3 returned for follow-up. Patient 3 acknowledged that she had tested positive two years before for the human immunodeficiency virus (HIV) and had not been treated. The Respondent referred Patient 3 to an Infectious Disease Specialist for evaluation and treatment for Highly Active Antiretroviral therapy (HAART). Patient 3 reported that she had also been prescribed Zoloft[15] in the past. The Respondent prescribed Zoloft to her along with the prescriptions for the antipsychotic medications. The Respondent did not conduct and/or document a mental status evaluation.

29. On October 26, 2016, Patient 3 returned for a follow-up visit. Patient 3 had failed to make appointments with either the psychiatrist or the Infectious Disease Specialist. The Respondent refilled her prescriptions for Seroquel, Depakote and Zoloft. The Respondent did not conduct and/or document a mental status evaluation.

30. The Respondent's care of Patient 3 as outlined above in whole or in part is evidence of the Respondent's failure to meet the standard of quality medical care in violation of Health Occ. II § 15-314(a)(22) and inadequate documentation in violation of Health Occ. II § 15-314(a)(40).

PATIENT 4

31. Patient 4, a female in her early 30s, was treated at Practice A on five separate occasions between December 9, 2015 and November 2016 for anxiety and depression. Patient 4 was prescribed Lexapro 20 mg[16] and Klonopin.[17]

32. On January 8, 2016, the Respondent saw Patient 4. Patient 4 complained of being high-strung, stressed, racing thoughts, sleeplessness, being overwhelmed by anxiety and

[15] Zoloft is an antidepressant in the category of Selective Serotonin Reuptake Inhibitors (SSRI).
[16] Used in the treatment of depression and general anxiety disorder.
[17] A Schedule IV sedative used in the treatment of seizures, panic disorder, and depression.

panic attacks. The Respondent increased Patient 4's Lexapro from 10 mg to 20 mg daily and started her on Seroquel. She continued Patient 4 on her Klonopin and advised that if she needed an increase, she would have to be evaluated by a psychiatrist.

33. The Respondent failed to document whether she had discussed with Patient 4 the possible side effects of Lexapro, which could potentially cause sleeplessness and racing thoughts.

34. The Respondent failed to conduct and/or document a mental status evaluation, including depression screening and/or assessment of suicidal and/or homicidal ideation.

35. The Respondent failed to conduct and/or document that she had educated Patient 4 as to the timeframe necessary after starting/increasing the Lexapro for mental status improvement.

36. The Respondent's care of Patient 4 as outlined above in whole or in part is evidence of the Respondent's failure to meet the standard of quality medical care in violation of Health Occ. II § 15-314(a)(22) and inadequate documentation in violation of Health Occ. § 15-314(a)(40).

INADEQUATE MEDICAL RECORDKEEPING

37. In addition to the deficiencies noted above in Patients 1, 3 and 4, the reviewer opined that the Respondent's recordkeeping was inadequate for Patients 5, 7, 8, 9 and 10.

38. Some examples of inadequate recordkeeping include but are not limited to:

- Inaccurate or incomplete history (Patients 8, 9, 10);
- Limited documentation of physical examination (Patients 5, 8, 9);
- Inadequate documentation of mental status evaluation (Patients 5, 7, 10);

- Failure to adequately document discussion(s) with supervising physician during complex patient interactions (Patient 5);
- Failure to update medication list (Patient 7); and/or
- Inadequate rationale for initiating treatment (Patient 8).

39. The Respondent's actions and inactions as outlined in pertinent part above in whole or in part evidence deficiencies in the Respondent's record keeping in violation of Health Occ. II § 15-314(a)(40).

II. CONCLUSIONS OF LAW

Based on the Findings of Fact, Panel B concludes as a matter of law that the Respondent's conduct constitutes violations of Health Occ. II § 15-314(a)(22) and (40).

III. ORDER

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

ORDERED that the Respondent is **REPRIMANDED;** and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of **TWO (2) YEARS.**[18] During the probationary period, the Respondent shall comply with all of the following probationary terms and conditions:

1. Within **SIX (6) MONTHS**, the Respondent shall successfully complete a Board disciplinary panel-approved course in prescribing, focusing on psychotropic medications. The course may not be used to fulfill the continuing medical education

[18] If the Respondent's license expires while the Respondent is on probation, the probationary period will be tolled.

credits required for license renewal. The Respondent must provide documentation to the Board that the Respondent has successfully completed the course;

2. The Respondent's medical practice shall be supervised in the following manner for a minimum period of **TWO (2) YEARS** by her physician supervisor who has been Board-approved through a Delegation Agreement.[19] The Respondent's supervisor must familiarize himself or herself with the relevant Board and Panel orders and peer review reports concerning the Respondent. The supervisor shall be available to the Respondent for consultations on any patient and shall observe the Respondent's practice and have access to the Respondent's patients' records and shall maintain the confidentiality of all medical records and patient information. The Respondent shall meet monthly with the supervisor to discuss the supervisor's review of ten (10) randomly selected patient records in which the Respondent has rendered medical care. Additionally, the Respondent shall ensure that the supervisor provides the Board with quarterly reports regarding the patient records reviewed and addressing whether there are any concerns with the Respondent. If there are indications that the Respondent poses a substantive risk to patients, the supervisor shall immediately report his or her concerns to the Board;

3. If the supervisor ceases his or her supervision of the Respondent for any reason prior to the Panel or Board's termination of Condition 2, it is the Respondent's responsibility to provide the Panel or the Board with any new physician supervisor approved by the Board through a delegation agreement.

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[19] Consistent with the Delegation Agreement entered into by the Respondent and her supervising physician, the terms and conditions of this Consent Order should not be construed as limiting the supervision of the supervising physician in any way.

4. During the probationary period, the Respondent is subject to a chart and/or peer review conducted by the Board or Board disciplinary panel or its agents; and it is further

ORDERED that, after **TWO (2) YEARS**, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board or Panel. The Respondent may be required to appear before the Board or Panel to discuss his/her petition for termination. The Board or Panel will grant the petition to terminate the probation if the Respondent has complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

ORDERED that there shall be no early termination of probation or of any conditions of this Consent Order; and it is further

ORDERED that if the Respondent allegedly fails to comply with any term or condition of this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If 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. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board or a Disciplinary Panel; and it is further

ORDERED that, after the appropriate hearing, if the Board or Disciplinary Panel determines that the Respondent has failed to comply with any term or condition of this Consent Order, the Board or Disciplinary Panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice medicine in Maryland. The Board or Disciplinary

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

ORDERED that the Respondent shall comply with all laws governing the practice of medicine under the Maryland Physician Assistants Act and all rules and regulations promulgated thereunder; and it is further

ORDERED that the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that, unless stated otherwise in the order, any time period prescribed in this order begins when the Consent Order goes into effect. The Consent Order goes into effect upon the signature of the Board's Executive Director, who signs on behalf of Panel B; and it is further

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., Gen. Prov. §§ 4–101 *et seq.*

01/22/2018
Date

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

CONSENT

I, Eden M. Sanchez, PA-C, by affixing my signature hereto, acknowledge that:

I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the sole purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

1/8/2018
Date

Eden M. Sanchez PA-C
Eden M. Sanchez, PA-C

STATE/ DISTRICT OF Maryland

CITY/COUNTY OF: Carroll

I HEREBY CERTIFY that on this 8 day of JAN, 2018, before me, a Notary Public of the State/District and County aforesaid, personally appeared Eden M. Sanchez, PA-C, and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Notary Public

NOTARY PUBLIC SEAL STATE OF MARYLAND
JASON COOKE
Notary Public
Carroll Co., MD
My Comm. Exps. 25 MAR 20

My commission expires: