IN THE MATTER OF	*	**BEFORE THE**
RALPH B. EPSTEIN, M.D.	*	**MARYLAND STATE**
Respondent.	*	**BOARD OF PHYSICIANS**
License Number: D08249	*	**Case Number: 2218-0269**

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FINAL DECISION AND ORDER

INTRODUCTION

On May 13, 2019, Disciplinary Panel B of the Maryland State Board of Physicians ("Board") charged Ralph B. Epstein, M.D., a gynecologist, with unprofessional conduct in the practice of medicine, under Md. Code Ann., Health Occ. § 14-404(a)(3)(ii). The charges alleged that Dr. Epstein treated three family members by prescribing medications, including controlled dangerous substances ("CDS"), and by performing medical procedures on them over the course of several years. After a one-day hearing before an Administrative Law Judge ("ALJ") at the Office of Administrative Hearings ("OAH"), the ALJ issued a proposed decision, on January 9, 2020. The ALJ concluded that Dr. Epstein was guilty of unprofessional conduct in the practice of medicine for treating his family members. The ALJ recommended a three-month suspension and a $25,000 fine.

On January 27, 2020, Dr. Epstein filed written exceptions to the ALJ's Proposed Decision. On February 3, 2020, the State filed a Motion to Strike Respondent's Exceptions. The State argued that Dr. Epstein's exceptions were largely a first-person narrative addressing his prescribing and medical care and thus improperly included evidence outside the record, based on statements that he had not presented as evidence at the OAH hearing. The State argued that Dr. Epstein, who briefly testified at the hearing, made a conscious decision to not testify at the

hearing about any substantive matters, and therefore, he should not be allowed to offer the testimony through the exceptions process.

Dr. Epstein was given the opportunity to respond to the State's motion, but did not file a response. Board Disciplinary Panel A ("Panel A" or the "Panel") granted the State's motion, in part, citing a Board's regulation, which states, "[t]he disciplinary panel may not accept additional evidence through the written exceptions process." COMAR 10.32.02.05B(1)(e). The Panel explained that the admission of this new information would not be fair to the Administrative Prosecutor, who would be unable to cross-examine witnesses to challenge the new information. On February 14, 2020, Panel A issued an Order Striking Additional Information not in Evidence from the Exceptions Proceeding. The Panel, however, declined to strike Dr. Epstein's written exceptions as a whole, noting that some of the exceptions appropriately contained arguments that were not based on additional evidence. On April 8, 2020, Panel A heard oral arguments on Dr. Epstein's remaining exceptions.

FINDINGS OF FACT

Panel A adopts the ALJ's Proposed Findings of Fact.[1] The ALJ's Proposed Findings of Fact (paragraphs 1-43) are incorporated by reference into the body of this document as if set forth in full.[2] *See* attached ALJ Proposed Decision, Exhibit 1. The factual findings were proven by a preponderance of the evidence. The Panel also adopts the ALJ's discussion set forth on pages 10-27 of the ALJ's proposed decision.

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[1] For purposes of confidentiality, the Board redacted the names, relationships, and, to the extent possible, the medications and medical conditions of Dr. Epstein's family members. The family members will be referred to in this Order as Family Member 1, Family Member 2, and Family Member 3.

[2] The Board modifies the following dates containing typographical errors in the summary of the evidence section: Page 2, State #3 is modified to November 14, 2012, State #6 is modified to January 21, 2016, Page 3, State #12, 13, 14 are modified to October 25, 2018, Resp #2 is modified to October 24, 2019. The Board modifies the following typographical errors in the discussion section: Page 18, line 7 is modified to begin "January 2017".

EXCEPTIONS

Dr. Epstein's remaining exceptions and oral exceptions fall into four categories. Dr. Epstein argues that: (1) his exceptions should not have been stricken; (2) his prescribing to family members was not unethical and therefore, was not unprofessional, (3) his prescribing was permissible because he was treating patients in emergency circumstances, and (4) the ALJ erred by rejecting his expert's witness's conclusions.

1. Exception regarding Motion to Strike

At the exceptions hearing, Dr. Epstein argued that he was not afforded the opportunity to defend his actions at the evidentiary hearing because the administrative prosecutor did not question him about those actions. As an initial matter, Dr. Epstein did not file a written response to the State's Motion to Strike and, therefore, has waived any arguments concerning the stricken exceptions. However, even had Dr. Epstein not waived this issue, his arguments have no merit. Dr. Epstein briefly testified and, therefore, had the opportunity to explain his actions. He chose not to testify on those matters at the hearing. He cannot later, months after the evidentiary hearing, add additional testimony that he could have presented at the evidentiary hearing. Panel A rejects his exceptions on this issue.

2. Dr. Epstein's Prescribing to Family Members

In his exceptions, Dr. Epstein challenged the ALJ's finding that prescribing to family members constitutes unprofessional conduct in the practice of medicine. Dr. Epstein argues that, because the laws and statutes do not expressly prohibit prescribing to a family member, no violation occurred. The State contends that the Board has consistently interpreted unprofessional conduct in the practice or medicine to include prescribing CDS and providing other medical treatment for family members.

Unprofessional conduct has been defined as "conduct which breaches the rules or ethical code of a profession." *Salerian v. Maryland State Board of Physicians* 176 Md. App. 231, 248 (2007) (citing *Finucan v Maryland Bd. of Physician Quality Assur.*, 380 Md. 577, 593 (2004)). Additionally, unprofessional conduct includes acts that are commonly understood by the profession to be prohibited. *See Salerian*, 176 Md. App. at 248. The lack of a specific statute or regulation that precludes treatment of family members does not limit the Panel's authority or ability to determine whether Dr. Epstein's treatment and prescribing to his family members was unprofessional. The Board's regulations state that "the disciplinary panels may consider the Principles of Ethics of the American Medical Association." COMAR 10.32.02.16. The American Medical Association ("AMA") Code of Medical Ethics' Opinion on Physicians Treating Family Members (Opinion 8.19) and the AMA's Code of Medical Ethics Opinion 1.2.1 were admitted into evidence and considered by the State's expert in reaching her conclusion that Dr. Epstein's conduct was unprofessional.

In both *Salerian* and *Finucan* the courts approved the use of the AMA Guidelines and an opinion of the AMA's Council on Ethical and Judicial Affairs, respectively, in determining whether the conduct at issue was unprofessional. *Salerian*, 176 Md. App. at 249; *Finucan*, 380 Md. at 593. In *Salerian*, the Court of Special Appeals accepted the AMA Guidelines as the ethical codes of medicine, which may be used to determine whether certain acts constitute unprofessional conduct. *Salerian*, 176 Md. App. at 249. In *Finucan*, the Court of Appeals concluded that a romantic relationship concurrent with a physician-patient relationship was unprofessional based on an opinion by the AMA's Council on Ethical and Judicial Affairs. *Finucan*, 380 Md. at 594. The *Salerian* Court relied on the testimony of the State's expert who

explained that Dr. Salerian's conduct violated the AMA's ethical standards. *Salerian*, 176 Md. App. at 249.

Here, Panel A relies on the testimony of the State's expert, who explained that it was inappropriate and unethical for Dr. Epstein to treat and prescribe medications, including CDS, to three family members. The State's expert based her opinion on her experience, training, the AMA Medical Ethics Opinions 8.19 and 1.2.1, the commonly understood opinion of the medical community, and prior Board precedent. Panel A places great weight on the State's expert's testimony and on the two referenced ethics opinions.

Ethics Opinion 8.19 states "[p]hysicians generally should not treat . . . members of their immediate family." The opinion discussed how "[p]rofessional objectivity may be compromised when an immediate family member . . . is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered." The ethics opinion states that "[p]hysicians may fail to probe sensitive areas when taking the medical history," and that, "[s]imilarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination." Particularly relevant here, "physicians may be inclined to treat problems beyond their expertise or training." Finally, the opinion states, "[e]xcept in emergencies, it is not appropriate for physicians to write prescriptions for controlled dangerous substances for . . . immediate family members."

The Panel adopts the ALJ's analysis regarding Dr. Epstein's unprofessional conduct. The Panel agrees that the concerns associated with treating a family member as described by AMA Ethics Opinion 8.19 and Opinion 1.2.1 are present in this case.

For Family Member 1, Dr. Epstein prescribed a Schedule II CDS with significant side effects thirty-nine times over a period of eighteen months. Dr. Epstein ignored significant red

flags, such as Family Member 1 requiring escalating doses, filling prescriptions at different pharmacies, and Family Member 1's statement that the Schedule II CDS was wearing off too soon. Moreover, Family Member 1's medical condition was not within Dr. Epstein's expertise and training as a gynecologist. Dr. Epstein's compromised professional objectivity likely contributed to his failure to heed the red flags indicating possible drug abuse or diversion.[3] Finally, the Ethics Opinion 8.19 explicitly states that, except in emergencies, it is not appropriate for a physician to prescribe CDS to family members. Dr. Epstein's prescribing CDS to Patient 1 over the course of several years does not qualify as an emergency.

For Family Member 2, Dr. Epstein prescribed two different Schedule IV CDS for a total of ten CDS prescriptions and several other non-CDS prescription drugs for medical conditions that were, again, outside his expertise. As will be explained further in the next section, the CDS was not prescribed in an emergency. The ALJ further found, and the Panel adopts the finding that Dr. Epstein did not maintain sufficient medical records nor did he document the patient's consent, which should have included informing the patient that the medication was found by the Federal Drug Administration to be ineffective for the condition which it was prescribed. He also operated on Family Member 2, performing significant elective surgeries. These elective surgeries were not performed in an emergency circumstance.

For Family Member 3, Dr. Epstein prescribed two different types of CDS, on one occasion for each drug, and did not document that he provided informed consent prior to prescribing a CDS that has a potential side effect. Dr. Epstein also prescribed several other

[3] Dr. Epstein further argues that his prescribing of this medication was not overprescribing. Dr. Epstein was not charged with a standard of care violation, nor does the Panel conclude that he was guilty of a standard of care violation for overprescribing. The Board does not find that Dr. Epstein engaged in overprescribing.

medications for Family Member 3, including at least one for which he did not document the condition that he was treating.

In addition, Dr. Epstein performed intimate examinations on Family Member 3, and he delivered her children. The ALJ considered the testimony of the State's expert and Dr. Epstein's expert and adopted the State's expert's reasoning. The ALJ explained that the "casualness of the treatment, compromised objectivity, personal feelings influencing professional judgment, and the reluctance of a patient to decline specific treatment are all legitimate concerns that may compromise the patient's care." Panel A adopts the ALJ's conclusion and reasoning.

The ALJ further found that for his treatment of his family members, Dr. Epstein did not follow the same practices and procedures as he did with his patients who were not in his family. Dr. Epstein's history taking, informed consent, and record keeping were not consistent with medical community standards. In sum, Panel A finds that Dr. Epstein's medical treatment of family members was unethical and unprofessional. His exceptions are rejected.

3. Emergency Situations

The AMA Code of Ethics Opinion 8.19 and Code of Medical Ethics Opinion 1.2.1 both contain exceptions for emergencies. Opinion 8.19 states, "In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat . . . family members until another physician becomes available." Additionally, "there are situations in which routine care is acceptable for short-term, minor problems." Opinion 1.2.1 has nearly identical language.

Dr. Epstein argued that he prescribed CDS to Family Member 2 on an emergency basis. At the exceptions hearing, Dr. Epstein further argued that his prescribing of a Schedule II CDS to Family Member 1 was an emergency because Family Member 1 had moved out of state and that

his prescriptions for Family Members 2 and 3 were merely short-term refills and, therefore, fell within the exception described in Ethics Opinion 8.19. Dr. Epstein's contentions are belied by the type of medications he prescribed, the duration of the prescribing, and the conditions treated.

Dr. Epstein prescribed a thirty-day supply of a Schedule II CDS with a high diversion and abuse potential to Family Member 1 on thirty-nine separate occasions during an eighteen-month period, which amounts to approximately a new prescription every two weeks. While the Board subpoenaed 18-months of prescriptions, Dr. Epstein's medical records indicate that Dr. Epstein prescribed Family Member 1 this Schedule II CDS for approximately five years. The CDS he prescribed is generally not prescribed by gynecologists and the condition he was treating was not within the practice of gynecology. Nor did Dr. Epstein merely provide refills of prescriptions initiated by other providers. Rather, Dr. Epstein changed the medication from one Schedule II CDS to another. Then he went back to the first CDS but increased the dosage. In any case, the prescribing went on for a period of years. These prescriptions were not written on an emergency basis, they were not isolated, and they were not used to treat a "short-term, minor problem."

Dr. Epstein prescribed Family Member 2 a three-month supply of a Schedule IV CDS with three refills.[4] A year's worth of medication is not prescribed for an emergency situation. Dr. Epstein asserts that, for a daily prescription of this drug, if a patient is out of medication and her prescribing physician is unavailable, it is an emergency and providing refills was not a violation of the code of ethics.

The evidence, however, does not indicate that Family Member 2's physician was unavailable. The Panel agrees with the State's expert that providing a one-year supply of a

[4] Dr. Epstein claims that he did not need to document Family Member 2's condition for this medication because it was documented in the family member's specialist's medical records. Panel A disagrees. Dr. Epstein was prescribing this CDS for the family member's condition, therefore, the medical condition should have been in the Dr. Epstein's medical records for that family member.

medication indicates that there was no emergency or short-term issue. Many of the prescription non-CDS medications were prescribed to Family Member 2 and Family Member 3 on a repeated basis and, therefore, were also not limited to emergency circumstances.[5] The Panel adopts the reasoning in the ALJ's proposed order and concludes that Dr. Epstein's prescriptions were not prescribed in an emergency nor do they fall under any exception discussed in AMA Ethics Opinion 8.19 or 1.2.1.

4. Dr. Epstein's Expert

Dr. Epstein argues that the Panel should adopt his expert's conclusion based on his expert's qualifications as the Practicing Chairman of the Department of OB/GYN at Hospital A. The ALJ, however, found Dr. Epstein's expert's testimony unpersuasive for several reasons. For his testimony related to Family Member 1, Dr. Epstein's expert admitted that he did not review the exhibits, and the Panel agrees with the ALJ that he, therefore, did not know all of the essential facts. Also, several of Dr. Epstein's expert's conclusions were based on information that was outside the record. For example, Dr. Epstein's expert based his opinion on information the expert received from Dr. Epstein's counsel that was not substantiated by evidence in the record.

Dr. Epstein also argues, based on his expert's testimony, that delivering family members' babies is not unprofessional. The ALJ considered the testimony of Dr. Epstein's expert and the

[5] In exception paragraph 10, Dr. Epstein challenges the ALJ's finding that the FDA has found that the use of a medication does not result in a certain outcome. His exception claims that, in fact, the medication does result in that outcome. Panel A finds no error in the ALJ's statements regarding the medication.

In each exception in paragraph 13 and 14, Dr. Epstein claims that certain medications were used for a particular treatment. However, the ALJ acknowledged that the medication could be used for the treatment in each case, and, therefore, it is not clear what is Dr. Epstein's objection. The ALJ describes the exact treatment that is listed in Dr. Epstein's exception in footnote 7 and paragraph 41, respectively. Dr. Epstein's exceptions are denied.

State's expert and found the State's expert more persuasive. The ALJ explained that Ethics Opinions 8.19 and 1.2.1 specifically warn about intimate examinations and intimate care and concluded that gynecological examinations performed on Family Member 3 and the delivery of her children should have been avoided. The Panel agrees. The ALJ correctly noted concerns about objectivity and the added emotional burdens of treating family members. As such, the ALJ upheld the finding of unprofessional conduct based, in part, on Dr. Epstein's treatment of Family Member 3. The Panel adopts the ALJ's well-reasoned analysis.

CONCLUSIONS OF LAW

Panel A concludes that Dr. Epstein is guilty of unprofessional conduct in the practice of medicine, in violation of § 14-404(a)(3)(ii) of the Health Occupations Article, for providing medical treatment to his family members, as described above.

SANCTION

The ALJ proposed a sanction of a three-month suspension and a $25,000 fine. The ALJ based the proposed sanction on Dr. Epstein's lengthy disciplinary history and his failure to understand that his behavior violated basic and fundamental professional and ethical principles. The ALJ also reasoned that Dr. Epstein's actions reflected a lack of insight as to his professional and moral obligations. The Panel adopts the ALJ's analysis but does not accept the ALJ's proposed sanction.

The current violation, prescribing CDS and treating family members is a significant violation that indicates a pattern of conduct. Dr. Epstein did not treat family members for brief periods of time. Rather, his lengthy course of treatment continued over a period of years through 2018 - five years for Family Member 1, beginning in 2001 for Family Member 2, and beginning in 2008 for Family Member 3. The State's expert expressed serious concerns about Dr.

Epstein's prescribing CDS to family members while failing to recognize red flags suggesting abuse or diversion. The State's expert was also concerned with the safety of Dr. Epstein's prescribing two medications that work at cross-purposes to Family Member 2. Dr. Epstein prescribed medications and otherwise treated family members outside his area of expertise. The Panel finds that his specific treatment of family members was disturbing and raises serious concerns about his medical judgment.

Dr. Epstein argues that the proposed sanction is "absurd" and "an attack on my character. I have been an upstanding member of this community and the medical community my entire life." But, as the State noted in its response to Dr. Epstein's exceptions, Dr. Epstein has a lengthy disciplinary history with the Board. Dr. Epstein has been reprimanded three separate times, suspended for 30 days, continuously on probation from 2007 through 2018, and was ordered to pay fines totaling $65,000. His violations have concerned patient care, honesty, and patient safety and are briefly summarized below.

In a 2007 Consent Order, the Board found that Dr. Epstein performed a surgical procedure, a panniculectomy, that he was not credentialed to perform, failed to document informed consent, accepted payment from the patient knowing that the procedure was rejected by the insurer for coverage. He also failed to name the procedure when posting the panniculectomy in the Operating Room or in the discharge notes, failed to dictate the procedure into the operative note, and allowed the hospital to bill the insurer for the operative time for the non-covered procedure. The Board found that Dr. Epstein violated the standard of care, failed to keep adequate documentation, and engaged in unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii), (22), and (40).

In a 2012 Consent Order, the Board found that Dr. Epstein inserted non-FDA approved Intrauterine Devices (IUDs) that he purchased through the Internet from Canada in fifteen patients but billed their insurance companies for implanting FDA-approved IUDs. He never informed those patients that he implanted non-FDA-approved IUDs and recorded in their medical records that they were FDA-approved IUDs. The Board found that he violated the standard of care, based on these insertions, based on his failure to provide informed consent about the placement of the non-FDA approved IUD and his failure to remove the IUD. Dr. Epstein was also found to have kept inadequate medical records by failing to record adequate informed consent, failing to document why procedures were necessary, failing to document the success or failure of the treatment, and failing to document whether non-operative treatments were discussed or attempted. The Board found Dr. Epstein was guilty of unprofessional conduct in the practice of medicine, willfully filed a false report or record in the practice of medicine, violated the standard of care, willfully submitted false statements to collect fees for which services were not provided, and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(3)(ii), (11), (22), (23), and (40) and found that he violated the 2007 Consent Order.

In a 2014 Consent Order, Disciplinary Panel B of the Board found that Dr. Epstein again implanted a non-FDA approved Mirena IUD without the patient's knowledge or consent, billed the patient's insurance company for implanting an FDA-approved NovaSure IUD, and altered the patient's medical record by replacing the Mirena IUD sticker with the NovaSure IUD sticker. Dr. Epstein was also found to have dispensed prescription drugs, specifically, the weight loss drug phentermine, to patients without a dispensing permit, and violated numerous dispensing laws and regulations. Panel B found that Dr. Epstein was guilty of unprofessional conduct in the

practice of medicine, willfully failed to file a medical report, and failed to comply with the dispensing regulations, in violation of Health Occ. § 14-404(a)(3)(ii), (12), (28), and violated the 2007 Consent Order again, as well as the 2012 Consent Order.

In a 2016 Consent Order, Disciplinary Panel B of the Board found that Dr. Epstein failed to wear gloves during a pelvic examination and failed to wash his hands prior to pelvic examinations, which demonstrated poor hand hygiene. Dr. Epstein also inappropriately stored 30 boxes of patient records in his house. Disciplinary Panel B found that Dr. Epstein was guilty of unprofessional conduct, in violation of Health Occ. § 14-404(a)(3)(ii), and that he violated the 2014 Consent Order.

The Panel takes into consideration that one of the aggravating factors when determining a sanction is that "[p]revious attempts to rehabilitate the offender were unsuccessful." COMAR 10.32.02.09.B(6)(k). This Final Decision and Order is the fifth time in 13 years that Dr. Epstein has been disciplined by the Board or by a Board Panel. The Board has given Dr. Epstein numerous chances to remedy his conduct and demonstrate that he can practice in a professional and ethical manner. Instead, Dr. Epstein has made clear that the prior discipline was ineffective in modifying his unprofessional and unethical behavior and that he is either unable or unwilling to practice medicine in a professional and ethical manner. As such, Panel A revokes Dr. Epstein's license and imposes a civil fine of $50,000.

ORDER

It is, by an affirmative vote of a majority of a quorum of the Disciplinary Panel A, hereby

ORDERED that the license of Ralph B. Epstein, M.D. to practice medicine in Maryland is **REVOKED**; and it is further

ORDERED that, within **ONE YEAR,** Dr. Epstein shall pay a $50,000 civil fine to be paid by certified check or money order payable to the Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297; 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).

06/03/2020
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. Epstein has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within 30 days from the date of mailing of this Final Decision and Order. The cover letter accompanying this final decision and order indicates the date the decision is mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

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

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

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

David S. Finkler
Assistant Attorney General
Department of Health and Mental Hygiene

300 West Preston Street, Suite 302
Baltimore, Maryland 21201

Exhibit 1

MARYLAND STATE BOARD OF	*	BEFORE GERALDINE A. KLAUBER,
PHYSICIANS	*	AN ADMINISTRATIVE LAW JUDGE
v.	*	OF THE MARYLAND OFFICE
RALPH B. EPSTEIN, M.D.,	*	OF ADMINISTRATIVE HEARINGS
RESPONDENT	*	
LICENSE No.: D08249	*	OAH No.: MDH-MBP1-71-19-27407

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PROPOSED DECISION

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

STATEMENT OF THE CASE

On May 13, 2019, a disciplinary panel of the Maryland State Board of Physicians (Board) issued charges against Ralph B. Epstein, M.D. (Respondent), alleging violations of the State law governing the practice of medicine. Md. Code Ann., Health Occ. §§ 14-101 through 14-508, and 14-601 through 14-607 (2014 & Supp. 2019)[1] (the Act). Specifically, the Respondent is charged with violating section 14-404(a)(3)(ii) of the Act. The disciplinary panel to which the complaint was assigned forwarded the charges to the Office of the Attorney General for prosecution, and another disciplinary panel delegated the matter to the Office of Administrative Hearings (OAH) for issuance of Proposed Findings of Fact, Proposed Conclusions of Law and Proposed Disposition. COMAR 10.32.02.03E (5); COMAR 10.32.02.04B (1).

[1] The Maryland Medical Practice Act (the Act).

I held a hearing on November 22, 2019 at the Office of Administrative Hearings, 11101 Gilroy Road, Hunt Valley, Maryland. Health Occ. § 14-405(a) (Supp. 2019); COMAR 10.32.02.04. Stephen L. Snyder, Esquire, represented the Respondent, who was present. Robert J. Gilbert, Assistant Attorney General and Administrative Prosecutor, represented the State of Maryland (State).

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules for Hearings Before the Board of Physicians, and the Rules of Procedure of the Office of Administrative Hearings. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2014 & Supp. 2019); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

1. Did the Respondent violate section 14-404(a)(3) of the Medical Practice Act by treating family members?
2. What sanctions, if any, are appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted into evidence the following exhibits offered by the State:

State #1- Licensing information, the Respondent

State#2 - Consent Order, October 1, 2007

State #3 - Consent Order, November 14, 2102

State #4 - Consent Order, April 9, 2014

State #5 - Order Terminating Suspension and Imposing Probation, May 19, 2014

State #6 - Consent Order, January 21, 2106

State #7 - Amendments to Consent Order of January 21, 2016, August 16, 2016

State #8 - Order Terminating Probation, January 22, 2018

State #9 - Complaint, March 7, 2018

State #10 - Disc containing Prescription Drug Monitoring Program (PDMP) report, Respondent

State #11 - Transcript of interview, Respondent, November 15, 2018

State #12 - *Subpoena Duces Tecum*, October 25, 2108 to Respondent; medical records of [redacted]

State #13 - *Subpoena Duces Tecum*, October 25, 2108 to Respondent; medical records of [redacted]

State #14 - *Subpoena Duces Tecum*, October 25, 2108 to Respondent; medical records of [redacted]

State #15 - Copies of prescriptions for [redacted]

State #16 - *Curriculum Vitae* of [redacted], January 18, 2019

State #17 - Expert report, [redacted], January 18, 2019

State #18 - AMA Code of Medical Ethics Opinion 8.19

State #19 - AMA Code of Medical Ethics Opinion 1.2.1

State #20 - Report of Investigation, March 15, 2019

I admitted into evidence the following exhibits offered by the Respondent:

Resp #1 - *Curriculum Vitae* of [redacted]

Resp #2 - Expert Report, [redacted] October 24, 2109

I admitted into evidence the following Joint exhibit:

Jt. #1 - Preface to the Opinions in the Code of Medical Ethics

Testimony

The following witnesses testified on behalf of the Board:

Doreen Noppinger, Compliance Manager, Board of Physicians;

[redacted], who was accepted as an expert in gastroenterology, obstetrics and gynecology.

The Respondent testified on his own behalf and presented testimony from [redacted] who was accepted as an expert in obstetrics and gynecology.

PROPOSED FINDINGS OF FACT

After considering the evidence, I find the following by a preponderance of the evidence:

1. At all times relevant hereto, Respondent was, and is, licensed to practice medicine in Maryland. Respondent was originally licensed to practice medicine in Maryland on August 3, 1970. His license is current until September 30, 2020.

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

Disciplinary history/Background

3. In 2007, the Board issued disciplinary charges against the Respondent. The Respondent resolved the charges by entering into a Consent Order with the Board, dated October 1, 2007, in which the Board found as a matter of law that the Respondent violated the Act, under Health Occupation Article section 14-404(a): (3) Is guilty of: (ii) (unprofessional conduct in the practice of medicine); (22) (fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care); (40) (fails to keep adequate medical records as determined by appropriate peer review).

4. The Board reprimanded the Respondent and placed him on probation for two years, subject to probationary conditions including payment of a $20,000.00 fine and training in medical ethics; and the requirement that he comply with all laws, rules and regulations governing the practice of medicine.

5. In 2012, the Board issued disciplinary charges against the Respondent. The Respondent resolved the charges by entering into a Consent Order with the Board, dated November 14, 2012, in which the Board found as a matter of law that the Respondent violated the Act, under Health Occupation Article section 14-404(a) (3) Is guilty of: (ii) unprofessional conduct in the practice of medicine; (23) Willfully submits false statements to collect fees for which services are not provided. The Board also found that the Respondent violated the terms of the 2007 Consent Order.

6. The Board reprimanded the Respondent and ordered him to remain on probation for a minimum period of two years, subject to probationary conditions including payment of a $20,000.00 fine and training in medical ethics and record keeping, and the requirement that he comply with all laws, rules and regulations governing the practice of medicine.

7. In 2013, the Board issued disciplinary charges against the Respondent. The Respondent resolved the charges by entering into a Consent Order with the Board, dated April 9, 2014, in which the Board found as a matter of law that the Respondent violated the Act, under section 14-404(a)(2) Fraudulently or deceptively uses a license; (3) Is guilty of: (ii) (unprofessional conduct in the practice of medicine); (11) Willfully files or makes a false report or record in the practice of medicine; (12) Willfully fails to file or record any medical report as required under law; willfully impedes or obstructs the filing or recording of the report, or induces another to fail to file or record the report; (17) Makes a willful misrepresentation in treatment; (23)Willfully submits false statements to collect fees for which services are not provided; (28) Fails to comply with the provisions of §12-102 of the Health Occupations Article.

8. The Board's 2014 Consent Order superseded the 2007 and 2012 Consent Orders. The Board suspended the Respondent's medical license for thirty days and placed him on probation for a minimum of three years, subject to probationary conditions including payment of a $25,000.00 fine and the requirement that he comply with all laws, rules and regulations governing the practice of medicine.

9. On May 19, 2014, the Board terminated the Respondent's thirty day suspension and placed him on probation for a minimum of three years and continuing until he successfully completed the probationary terms and conditions.

10. On August 20, 2015, the Board charged the Respondent with violating the probationary conditions imposed under the Consent Order dated April 14, 2014 and May 19, 2014 Order. The Respondent resolved the charges by entering into a Consent Order with the Board, dated January 21, 2016, in which the Board found as a matter of law that the Respondent violated the Act, under Health Occupation Article section 14-404(a) (3) Is guilty of: (ii) (unprofessional conduct in the practice of medicine) and the conditions imposed by the April 14, 2014 Consent Order and the May 19, 2014.

11. The Board reprimanded the Respondent and placed him on probation for a minimum of a two-year period, subject to series of probationary conditions, including paying a fine of $5,000.00 and the requirement that he comply with all laws, rules and regulations governing the practice of medicine.

12. On March 7, 2018, an individual filed a complaint against the [redacted] [redacted] (Center) in Columbia, Maryland regarding the receipt of medical treatment and prescriptions from unlicensed individuals. The Respondent was one of the health care providers employed by the clinic and was named in the complaint.

13. The Board did not issue any charges against the Respondent for his involvement with the Center.

14. During the investigation of the complaint, the Board obtained the Respondent's prescribing activities for the period of January 1, 2017 through June 13, 2018 from the PDMP. The PDMP reflected that the Respondent had been prescribing controlled dangerous substances (CDS) to family members.

[redacted]

15. Over the course of five years, the Respondent prescribed [redacted] to [redacted]. For the period of January 2017 through June 2018 there were thirty-nine entries in the PDMP for [redacted][2] prescriptions written by the Respondent for [redacted].

16. [redacted] is a designated by the Drug Enforcement Agency as a schedule 2 drug.[3]

17. [redacted], who is [redacted] years of age, has been treated for [redacted] and has been prescribed [redacted] since [redacted].

18. In December 2013, the [redacted] documents on the Respondent's patient intake form that he takes [redacted] three times per day. (Board #12)

19. In March 2017, the [redacted] reported that he feels like the [redacted] wears off too soon. In response, the Respondent increased his [redacted] dosage [redacted].

20. On January 15, 2018, the Respondent prescribed [redacted] ninety tablets [redacted]. Two weeks later, the Respondent prescribed 90 more tablets of [redacted], and on February 9, 2018, he prescribed sixty tablets [redacted].

---

[2] [redacted]

[3] The DEA's drug scheduled organizes drugs into groups based on risk or abuse or harm. A schedule 2 drug has high potential for abuse and diversion.

21. In July 2018, the Respondent took [redacted] off [redacted] and prescribed him [redacted]. After a brief stint on [redacted] the Respondent took [redacted] off [redacted] and returned him to [redacted].

22. [redacted] filled some of the prescriptions at different pharmacies.

23. The Respondent did not consult with [redacted] physician prior to prescribing the [redacted].

[redacted]

24. PDMP report pertaining to the Respondent for the period of January 2108 through June 2018 includes ten entries for prescriptions for [redacted]. Six entries were for [redacted] and four entries were for [redacted].

25. [redacted] is a schedule 4 drug used for [redacted]. One of the possible side effects of [redacted] is [redacted].

26. [redacted][4] is [redacted], schedule 4, typically prescribed to treat [redacted]. The Respondent prescribed three months supplies of [redacted] with three refills, the equivalent of a one year supply.

27. The Respondent informed the Board that he prescribed the [redacted] for [redacted][5] There is no documentation of [redacted] in [redacted] medical records.

28. The Respondent did not prescribe [redacted] on an emergent basis.

[redacted]

29. In 2001, the Respondent operated twice on [redacted]. He performed [redacted], both are elective procedures and are considered significant procedures.

30. There is nothing in [redacted] medical records to reflect the Respondent had obtained [redacted] consent before operating.

31. On October 23, 2017, the Respondent prescribed [redacted] for [redacted]. The FDA has stated [redacted] does not cause [redacted] and has mandated that homeopathic products containing [redacted] for [redacted] be taken off the market. The medical records do not reflect that the Respondent received informed consent from [redacted] regarding the FDA's findings before prescribing her [redacted].

32. The Respondent performed [redacted] on [redacted].

33. The Respondent has referred [redacted] for Magnetic Resonance Imaging (MRI) of [redacted].

34. The Respondent provided gynecological care to [redacted], including routine pelvic examinations and the delivery of two children.

35. [redacted] asked the Respondent to deliver her first child when her obstetrician, who practiced with the Respondent, was not on call.

36. [redacted] preferred that the Respondent provide her with gynecological and obstetrical care, which included pelvic examinations, breast examinations and delivering two children.

37. [redacted] has a history of [redacted]. Another physician had prescribed her medication for the condition.

38. In June 2016, the Respondent prescribed [redacted] for [redacted].

39. The [redacted] underwent [redacted]. On two occasions, the Respondent prescribed her [redacted] for [redacted] [redacted].[6] [redacted] is a schedule 5 [redacted].

40. On April 15, 2017, the Respondent prescribed [redacted] twenty tablets of [redacted].[7]

41. On May 19, 2016, the Respondent prescribed [redacted], which is an [redacted] medication.

42. The Respondent prescribed [redacted] [redacted]. [redacted]'s medical records do not document any reported [redacted]

43. Upon notice by the Board of its charges, the Respondent stopped treating his family members, including not prescribing medications.

DISCUSSION

Legal Background

The Board maintains that the Respondent is subject to discipline for violating the following provisions of the Maryland Medical Practice Act:

> (a) *In general.* – 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

[6] The one prescription was written on July 17, 2015 and was [redacted] (410). The other prescription was called in and there was no date on the documentation.

[7] [redacted]

disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

...

(3) Is guilty of:

...

(ii) Unprofessional conduct in the practice of medicine;

Health Occ. § 14-404(a)(3)(ii) (Supp. 2019).

Before the Board takes any action under section 14-404(a), the individual against whom the action is contemplated is entitled to the opportunity for a hearing before an Administrative Law Judge (ALJ) at the OAH. Factual findings made by the ALJ shall be supported by a preponderance of the evidence. Md. Code Ann., Health Occ. § 14-405(b)(2) (2014).

The State, as the moving party, bears the burden to prove by a preponderance of the evidence that the Respondent violated the statutory provisions at issue. Md. Code Ann., State Gov't § 10-217 (2014); Md. Code Ann., Health Occ. § 14-405(b)(2) (2014); *Comm'r of Labor & Indus. v. Bethlehem Steel Corp.*, 344 Md. 17, 34 (1996) (citing *Bernstein v. Real Estate Comm'n*, 221 Md. 221, 231 (1959)). As discussed below, I find that the State has met its burden with respect to the charges.

While the Act fails to provide any standard for or definition of the phrase "unprofessional conduct," the Maryland Court of Appeals defined the term to include conduct that breaches rules or ethical codes of professional conduct or conduct unbecoming to a member in good standing in the profession. *Finucan v. Maryland Bd. of Physicians Quality Assurance*, 380 Md. 577, 593, *cert. denied*, 543 U.S. 862 (2004).

Arguments of the Parties

The Board alleged that the Respondent was responsible for unprofessional conduct in the practice of medicine in violation of section 14-404(a)(3)(ii) of the Health Occupations Article based on his actions in prescribing CDS and prescription only medications to family members, and for providing medical care to those family members.

In support of its case, the State presented testimony of [redacted] is Board certified in internal medicine and gastroenterology. She was qualified and accepted as an expert in internal medicine, gastroenterology, and professional ethics. [redacted] served as a member of the Maryland Board of Physicians from 1999 until 2003. She continued to practice medicine until 2014, at which time she retired. In April 2015, [redacted] became a clinical physician consultant for the Board and currently serves in that capacity. [redacted] duties as Board consultant include reviewing the majority of complaints filed with the Board, which she estimates to be approximately one thousand per year. She also reviews the Licensee complaints, subpoenas related records, reviews the standard of care and/or ethical opinions and ultimately formulates a summary and opinion. [redacted] concluded that the Respondent's treatment and prescribing practices to family members constituted unprofessional conduct in the practice of medicine. [redacted] explained that in formulating her opinions she considered Board precedent, AMA ethical opinions, and her knowledge gained from practice and discussions with peers.

The State also presented testimony of Doreen Noppinger, Compliance Manager, Board of Physicians. Ms. Noppinger set forth the prior disciplinary history of the Respondent to be taken into consideration when fashioning a sanction.

The State argued that while the State considers mitigating and aggravating factors in recommending a sanction, in this case there are no mitigating factors but there are aggravating factors. The State argued the Respondent's prescribing of CDS and other prescription medications to his family was pervasive, particularly in regard to [redacted], and therefore merits a sanction. The State argued that the most significant aggravating factor is the Respondent's prior disciplinary history, which includes multiple acts of unprofessional conduct in the practice of medicine, misrepresentations as well as violations of the standard of care. As a disciplinary measure the State seeks a three-month suspension of licensure and a fine of $25,000.00.

The Respondent did not deny that he prescribed both CDS and prescription only medications to three family members, nor did he deny providing medical treatment to those family members. The Respondent argued that his conduct, although perhaps in some instances was somewhat inappropriate, did not rise to the level of unprofessional conduct. The Respondent argued that [redacted] testimony and opinions should be disregarded because she is a biased witness who is employed by the Board. The Respondent presented an opposing opinion from [redacted], an expert in the gynecology and obstetrics. [redacted] opined that based upon his review of the facts, the Respondent's treatment of his family members was not unprofessional conduct in the practice of medicine. [redacted] disagreed with [redacted] interpretation of the AMA Medical Ethical Opinions as prohibiting physicians from prescribing medications and treating family members. According to [redacted], the Respondent's actions did not constitute unprofessional conduct in the practice of medicine.

Analysis

Prescribing to family members

The Board charged the Respondent with unprofessional conduct in the practice of medicine in regard to his prescribing practices to family members. The evidence offered by the Board established that the Respondent prescribed controlled substances t[redacted]. The evidence also established that the Respondent operated on [redacted] on two occasions, provided routine gynecological care for [redacted] and delivered her two children. For the reasons explained below, I find that the Respondent engaged in unprofessional conduct in the practice of medicine.

[redacted] provided a definition of unprofessional conduct in the practice of medicine as conduct that does not comport with AMA's Code of Medical Ethics Opinions or will breach a standard of medical ethics in a medical community that is in good standing. [redacted] definition is consistent with the Court of Appeals definition stated *Finucan, supra.*

[redacted] testified that she is the Clinical Physician Consultant for the Board and reviews the majority of complaints that come to the Board. She explained that her review of the Respondent's case originated from a complaint against the [redacted] Center where the Respondent was employed. Her review of the complaint included a review of the Respondent's PDMP records for the period of January 1, 2017 through June 13, 2018, the hard copies of prescriptions written by the Respondent for his family members, and the medical records of [redacted]. She also reviewed the AMA Code of Medical Ethics Opinions, specifically Opinions 8.19 and 1.2.1. [redacted] explained that while she considered the AMA Code of Medical Ethical Opinions when conducting her review, her opinions were based largely on her experience, training, and Board precedent.

There are no federal or Maryland laws, regulations or written policies that preclude physicians from treating immediate family members. The Opinions of the Code of Medical Ethics are also not laws or rules, but as the Preface states, are a guide for physicians on ethical behavior. A physician's deviation from the guidance offered in the AMA Code of Ethics and the Ethical Opinions, however, may support a finding that a physician engaged in unprofessional conduct in the practice of medicine.

Opinion 8.19 states:

> Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.
>
> Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.
>
> It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

Opinions 8.19 in conjunction with Opinion 1.2.1 delineate specific concerns that may arise when a physician treats family members. The following listed concerns support the AMA's disapproval of physician's treating family members:

- Professional objectivity may be compromised;
- Personal feelings may unduly influence a physician's professional medical judgment;
- Physicians may fail to probe sensitive areas when taking medical histories or fail to perform intimate parts of physical examinations;
- Patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination;
- Physicians may be inclined to try and treat problems beyond their medical expertise and training;
- Negative medical outcomes may be carried over into the personal/family relationship with the physician;
- Family members may feel reluctant to decline treatment recommended by the physician;
- Physicians may feel obligated to provide care to family even if they feel uncomfortable doing so.

Opinion 1.2.1 states, in part:

> Treating oneself or a member of one's own family poses several challenges for physicians, including concerns about professional objectivity, patient autonomy and informed consent.

[redacted] testified that when she reviewed the Respondent's case, she considered Opinion 8.19, which specifically finds a physician's prescribing of CDS to family members inappropriate, except in cases of emergency. [redacted] had particular concern about the Respondent's

prescribing practices regarding [redacted]. [redacted] was diagnosed with [redacted] as a teenager and was prescribed [redacted] to treat the condition. The medical records reflect that the Respondent's prescribing of [redacted] dates back to 2013. [redacted] is currently [redacted] years old and still taking the medication. The PDMP reflects thirty-nine entries for the period of January 1, 2017 through June 13, 2018 and during that period the Respondent prescribed the medication more than once a month. On March 2, 2017, the Respondent increased the [redacted] dosage to [redacted] after [redacted] reported to him that he feels as if the [redacted] wears off too soon. In July 2018, the Respondent changed [redacted] course of treatment to [redacted] for a short time and then returned to prescribing [redacted].

[redacted] explained that the concern of a physician's lack of objectivity when prescribing CDS to family members occurred in the Respondent's prescribing practices with [redacted]. The Respondent prescribed [redacted] to [redacted] over an extended period of time. As with all CDS, [redacted] carries with it the risk of diversion or abuse. [redacted] testified that the Respondent ignored red flags associated with [redacted] use of the CDS. Specifically, [redacted] filling of prescriptions at different pharmacies, his need for increased dosages, and his statement that he felt as if [redacted] was wearing off too soon, should have been red flags of possible abuse or diversion. The Respondent, however, ignored these signs and continued to prescribe the drug without any apparent recognition of potential problems.

[redacted] noted the additional concern with a physician prescribing CDS to a family member is the risk that a physician may assume the treatment of a condition that is outside of his/her area of expertise. This was the case with the Respondent's treatment of [redacted]. The Respondent's expertise is gynecology and obstetrics and [redacted] is a [redacted], which is in the realm of expertise of a psychologist, psychiatrist, or neurologist. The

Respondent's continued treatment of [redacted] by altering his doses of [redacted], and at one point taking him off [redacted] and prescribing [redacted] in its stead, was clearly treatment outside of the Respondent's area of expertise. As [redacted] noted, it would have been in the [redacted] best interest to have been treated by a psychiatrist or practitioner who had expertise in the treatment of [redacted] and could better adjust medications and monitor his condition.

In addition to prescribing CDS to [redacted], the PDMP for the eighteen-month period of January 2108 through June 2018 includes ten entries for CDS prescribed by the Respondent for [redacted]. Six entries were for [redacted] and four entries were for [redacted]. The Respondent prescribed three months supplies of [redacted] with three refills, the equivalent of approximately a one year supply. In his interview with the Board, the Respondent stated that he had prescribed [redacted].

The Respondent's prescribing of [redacted] to [redacted] is in contravention of the guidance offered by the Ethical Opinions and Board precedent regarding the prescribing of CDS to family members. Other than the general concern of the dangerous nature of CDS, [redacted] pointed out other specific concerns with the Respondent's prescribing practices pertaining to [redacted]. The Respondent testified before the Board that he prescribed [redacted] to treat [redacted], yet there is no documentation in the medical records that she had this condition. [redacted] testified that [redacted] was an unusual condition for which to prescribe [redacted]. Additionally, the Respondent prescribed [redacted] which carries with it a possible side effect [redacted]. Therefore, if the Respondent's reason for prescribing the [redacted] is accurate, the Respondent provided [redacted] overlapping prescriptions, [redacted] was possibly causing symptoms that the [redacted] had been prescribed to prevent.

The medical records further reflect that on October 23, 2017, the Respondent started [redacted], which is used for [redacted]. The FDA has stated [redacted] does not cause [redacted] and has mandated that homeopathic products containing [redacted] for [redacted] be taken off of the market. [redacted] noted that the issue of the Respondent's prescribing of [redacted] is that the medical records do not reflect that the Respondent provided [redacted] with informed consent regarding the FDA's findings.

The Respondent also prescribed CDS to [redacted]. The PDMP for the period previously referenced reflects that the Respondent prescribed [redacted] on June 24, 2017, and [redacted] on May 18, 2018. [redacted] pointed out that the Respondent's [redacted]. Although there was no overlap in the prescribing of medication for [redacted], as previously noted, [redacted] can cause [redacted]. [redacted] stated that although it was not an absolute contraindication to prescribe [redacted] for [redacted] purposes in the setting of [redacted], the Respondent should have discussed with [redacted] the possible issues with the [redacted], and there is nothing in the record to indicate that the Respondent obtained informed consent prior to prescribing the medication.

In addition to [redacted], the Respondent prescribed [redacted] three times in 2011. [redacted] pointed out that although it is not unusual for a gynecologist to refill [redacted] for a Patient; [redacted] medical records did not document [redacted] or initiation of the drug by another physician.

The Respondent also prescribed several prescription-only drugs to [redacted], including drugs for [redacted]. Prescriptions for [redacted] included [redacted] on short term basis. While not as concerning as the

prescribed CDS, his prescribing drugs to [redacted] is activity clearly frowned upon by the Ethics Opinions. His actions were part of the Respondent's overall pattern of ignoring the guidance offered by the AMA Ethical Opinions.

One of the concerns of a physician treating or prescribing medication to a family member is that the physician's treatment will be too casual and not follow the same standards as those adhered to for unrelated patients. It appears that this is precisely what occurred in the Respondent's treatment of his family. The Respondent's history taking, obtaining informed consent, and record keeping for family members was not in line with the medical community's standards.

In my consideration of the weight to be given [redacted] testimony, I have rejected the Respondent's argument that [redacted] was biased by virtue of her employment with the Board and, therefore, her testimony should be discarded. Although I recognize that [redacted] is a Board employee, because her explanations for the basis of her opinions were rational and supported by the facts and precedent, I found her testimony worthy of consideration.

On the other hand, regarding the issue of the Respondent's practice of prescribing CDS to his family, the Respondent's expert's opinion that the Respondent's actions did not constitute unprofessional conduct was not based on accurate facts. First, [redacted] did not have all the essential facts before him as he admitted that he did not review the exhibits that were admitted into evidence prior to rendering his opinion. Additionally, [redacted] rationale for finding that the Respondent's prescribing of CDS to [redacted] did not rise to the level of unprofessional conduct was based on the premises that another physician initially prescribed [redacted], and the Respondent was not the primary physician overseeing the care of [redacted] for the condition. Although [redacted] intake form identified Dr. [redacted] as his physician, the form also noted there

was no treating physician. The Respondent's medical records made no reference to another physician overseeing [redacted] care. [redacted] testified that he understood tha[redacted] treatment for [redacted] was overseen by another physician from what he had been told by the Respondent's attorney.

Many of the concerns about prescribing CDS and prescription-only drugs to family members enumerated in the relevant Medical Opinions were manifest in the Respondent's prescribing to his family members, and for the reasons set forth in [redacted] testimony, I find that the evidence supports a finding that the Respondent's actions in this regard constituted unprofessional conduct in the practice of medicine.

In addition to finding the Respondent's prescribing of CDS to family members unprofessional conduct, the Board also found the Respondent's rendering of medical care to his family members unprofessional. The Respondent provided routine gynecological care to [redacted] and delivered her two children. It is undisputed that [redacted] had no issues or concerns with [redacted] treating her or delivering her children. It was [redacted] who approached the Respondent and requested that he deliver her first child when her obstetrician was not on call the day of her delivery.

[redacted] testified that Ethical Opinion and Board precedent led her to conclude the Respondent's conduct of providing gynecological and obstetric care to [redacted] was unprofessional. [redacted] referenced Opinion 1.2.1 which provides, in relevant part:

> In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:
>
> (a) In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available.
>
> (b) For short term, minor problems.

When treating self or family members, physicians have further responsibility to:

(c) Document treatment or care provided and convey relevant information to the patient's primary care physician.

(d) Recognize that if tensions develop in the professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

(e) Avoid providing sensitive or intimate care especially for a minor patient who is uncomfortable being treated by a family member.

(f) Recognize the family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

According to [redacted], the Medical Opinions, which specifically state that a physician should avoid providing sensitive or intimate care to a family member, also support a finding of unprofessional conduct. She further noted that it is the well-recognized opinion of the medical community that it is "inappropriate and unethical" for a physician to treat family members and Board precedent also deems the treatment as unprofessional conduct.

In response to the State's case, the Respondent argued that the Ethical Opinions do not support the charges against the Respondent because the Opinions do not specifically use the terms unethical or unprofessional. The Respondent also pointed to the Preface to the Code of Medical Ethics which states that the words *must*, *should* and *may*, which appear throughout the Opinions are used in their common understandings to distinguish different levels of ethical obligation. According to the Respondent, because Opinion 8.19 states that physicians "generally *should* not treat themselves or members of their immediate families," and does not state "*must*" not treat family members, the physician is afforded latitude in this area. (Joint Ex. 1)

[redacted], who is the Chair of the Obstetrician/Gynecology Department at Mercy Medical Center, testified that in his opinion the Respondent's treatment of [redacted] was not unprofessional and was within the standard of care. He interpreted the Opinion's reference to the inappropriateness of intimate care to pertain to minors only. He also testified that the AMA Ethical Opinions are purely a guide and not a strict code and give latitude to physicians in making their own decisions regarding patient care. [redacted] testified that she was totally complicit in the Respondent treating her and delivering her children. [redacted] placed emphasis on this fact and noted that [redacted] had no issues or reservations with the Respondent providing her routine gynecological care or delivering her children. He testified that he is familiar with numerous physicians in the field who have provided care for [redacted]. [redacted] took particular exception to [redacted] assertion that the Respondent provided intimate care to [redacted], his reasoning being that pelvic exams are routine examinations for gynecologists and obstetricians. He described a vaginal exam as a tool for the doctor - similar to a stethoscope as a tool for a cardiologist.

The fact that two highly qualified and experienced physicians have starkly different opinions on the appropriateness of the Respondent's treatment of [redacted] is proof of the complexity of the issue.

I did not find [redacted] opinion that pelvic exams are not intimate care persuasive. Gynecological care address a woman's most intimate body parts and because gynecologists and obstetricians examine vaginas on a routine bases does not make the examinations any less intimate to a female patient. I would imagine that most, if not all, women consider the birth of a child one of the most intimate experiences in their lives. While I agree that the relevant Ethics

Opinion regarding intimate care does not use the words "must not," the Opinion does not use the words may or should either. The Opinion, however, states unequivocally that a physician has responsibility to avoid providing intimate care to family members. The responsibility is not limited to children, as suggested by the Respondent's interpretation of the Opinion, but adds emphasis to this responsibility in the case of a minor patient.

I have considered [redacted] consent and recognize the importance of a women's right to choose a physician who will provide her with intimate care and deliver her children. I also recognize that a patient may have a myriad of reasons, including convenience, religion, and family ties for finding gynecological care by a family member not only acceptable but desirable. A physician, however, is charged with ethical and professional obligations that may not be apparent to the family member seeking his/her services and it is the physician's responsibility to uphold these standards which trump a family member's wishes.

The same concerns expressed by [redacted] regarding a physician prescribing drugs to family members exist in a physician's hands-on treatment of a family member. The casualness of the treatment, compromised objectivity, personal feelings influencing professional judgment, and the reluctance of a patient to decline specific treatment are all legitimate concerns that may compromise the patient's care. [redacted] was fortunate that her pregnancies and deliveries were without complications, but one can imagine the possible legal, emotional and medical repercussions that would befall a physician and his relative if the pregnancy and delivery involved complications that threatened the health of the baby and/or the mother. Would the physician's objectivity remain intact allowing him to make medically sound decisions? Would he be able to exercise appropriate medical judgment under the duress of treating family? These are reasonable questions and highlight the Board's logic in deeming the

Respondent's treatment of [redacted] unprofessional. The Board is ultimately charged with the onerous duty of assuring quality health care in Maryland by protecting the public from incompetent, unprofessional and poorly trained doctors. The Board's precedent in finding that a physician's treatment of family members constitutes unprofessional conduct in the practice of medicine should be granted deference.

In addition to providing intimate care to [redacted], the Respondent operated twice on [redacted]. In 2001, he performed a [redacted]. [redacted] described the surgeries as significant elective surgeries to address [redacted]. The same reasons articulated for finding the Respondent's treatment of [redacted] unprofessional conduct apply to his treatment of [redacted].

Sanctions

Having found the State proved the Respondent violated the Maryland Medical Practice Act with respect to his treatment of three family members, I now turn to the question of what sanction or fine, if any, is appropriate. The minimum sanction for immoral or unprofessional conduct in the practice of medicine, that is not sexual in nature, is a reprimand and the maximum is revocation. The maximum fine is $50,000.00 and the minimum fine is $5,000.00. COMAR 10.32.02.10B(3)(c).

The guiding regulation in this matter, found at COMAR 10.32.02.09B, provides in pertinent part as follows:

> B. Aggravating and Mitigating Factors.
>
> (1) Depending on the facts and circumstances of each case, and to the extent that the facts and circumstances apply, the disciplinary panel may consider the aggravating and mitigating factors set out in §B(5) and (6) of this regulation and may in its discretion determine, based on those factors, that an exception should be made and that the sanction in a particular case should fall outside the range of sanctions listed in the sanctioning guidelines.

...

(5) Mitigating factors may include, but are not limited to, the following:

(a) The absence of a prior disciplinary record;
(b) The offender self-reported the incident;
(c) The offender voluntarily admitted the misconduct, made full disclosure to the disciplinary panel and was cooperative during the disciplinary panel proceedings;
(d) The offender implemented remedial measures to correct or mitigate the harm arising from the misconduct;
(e) The offender made good faith efforts to make restitution or to rectify the consequences of the misconduct;
(f) The offender has been rehabilitated or exhibits rehabilitative potential;
(g) The misconduct was not premeditated;
(h) There was no potential harm to patients or the public or other adverse impact; or
(i) The incident was isolated and is not likely to recur.

(6) Aggravating factors may include, but are not limited to, the following:

(a) The offender has a previous criminal or administrative disciplinary history;
(b) The offense was committed deliberately or with gross negligence or recklessness;
(c) The offense had the potential for, or actually did cause patient harm;
(d) The offense was part of a pattern of detrimental conduct;
(e) The offender committed a combination of factually discrete offenses adjudicated in a single action;
(f) The offender pursued his or her financial gain over the patient's welfare;
(g) The patient was especially vulnerable;
(h) The offender attempted to hide the error or misconduct from patients or others;
(i) The offender concealed, falsified or destroyed evidence, or presented false testimony or evidence;
(j) The offender did not cooperate with the investigation; or
(k) Previous attempts to rehabilitate the offender were unsuccessful.

I have considered the mitigating factors in this case to be that the Respondent acted with only good intentions in treating his family members and no harm resulted from his treatment. I have also noted that his unprofessional conduct was limited to treatment of [redacted] and his actions in no way impacted his general practice or the public. It also reflects favorably

upon the Respondent that upon notice of the charges, he immediately ceased treatment of his family in any capacity.

The aggravating circumstances in this case are the facts that the Respondent's treatment of some of his family members continued over an extended period of time, and the Respondent's extensive history with the Board. As the State pointed out, the Respondent has had previous charges lodged against him by the Board that included misrepresentations, unprofessional conduct in the practice of medicine, and violations of the standard of care. As a result of the previous violations, the Respondent was on probation from 2007 to 2018 and has been required to take various courses in ethics and record keeping. In addition, the Respondent has received fines totaling $65,000.00.

In addition to these aggravating circumstances, I have considered the Respondent's testimony at the hearing that the treatment of his family may have been "inappropriate" or "ill-advised" but was not unprofessional or in violation of the Code of Ethics. Based on his extended disciplinary history and his failure to acknowledge that his behavior was in contravention of the code of ethics and unprofessional reflects a lack of insight as to his professional and moral obligations as provided for in the Code of Ethic. Therefore, I find the State's proposed sanction consisting of a three-month suspension and a $25,000.00 fine is appropriate.

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude as a matter of law that the Respondent did violate the Maryland Medical Practice Act. Md. Code Ann., Health Occ. § 14-404(a)(3)(ii) (Supp. 2019). As a result, I conclude that the Respondent is subject to disciplinary sanctions for the cited violations. *Id.*; COMAR 10.32.02.09A-B.

PROPOSED DISPOSITION

I **PROPOSE** that charges filed by the Maryland State Board of Physicians against the Respondent on May 13, 2019 be **UPHELD**; and

I **PROPOSE** that the Respondent be sanctioned by a three-month suspension and $25,000.00 fine.

January 9, 2020
Date Decision Issued

Geraldine A. Klauber
Administrative Law Judge

GAK/sw
#183424

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 State 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) (2014); 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 (2014); COMAR 10.32.02.05C. The OAH is not a party to any review process.

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