IN THE MATTER OF	*	**BEFORE THE**
PAUL PRITCHETT, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D08370	*	**Case Nnmber: 2219-0119-A**

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CONSENT ORDER

On July 6, 2020, Disciplinary Panel A of the Maryland State Board of Physicians (the "Board") charged **PAUL PRITCHETT, M.D.** (the "Respondent"), License Number: D08370, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.*

The relevant provisions of the Act under Health Occ. § 14-404(a) provide the following:

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
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> . . .
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> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State[.]

On October 7, 2020, Panel A 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, Order, and Consent.

FINDINGS OF FACT

Panel A finds the following:

I. BACKGROUND

1. At all relevant times, the Respondent was and is a physician licensed to practice medicine in the State of Maryland. He was initially licensed in Maryland on August 13, 1970. The Respondent's license is presently active.

2. The Respondent specializes in family medicine.

3. The Respondent operates a general solo practice in La Plata, Maryland.

II. COMPLAINT

4. The Board opened an investigation after receiving a Complaint from the daughter of a patient alleging that the Respondent had been prescribing large quantities of controlled dangerous substances (CDS) to a Patient, identified herein as Patient One.

5. After receiving the Complaint, the Board initiated an investigation.

6. In furtherance of its investigation the Board interviewed the Respondent and subpoenaed ten (10) patient medical records.

7. The Board then requested that two peer reviewers review the patient records to determine whether the Respondent complied with the appropriate standard of care and medical recordkeeping.

III. SUMMARY OF PEER REVIEW FINDINGS

8. The peer reviewers determined that overall, the Respondent did not meet the appropriate standard of care for the delivery of quality medical care in 5 of the 10 cases reviewed, for a number of reasons, including but not limited to the following:

(a) The medical record did not include baseline drug screening evaluation;

(b) The Respondent failed to discuss with patient the known risks and benefits of opioid therapy;[1]

(c) The Respondent failed to obtain adequate patient informed consent for opioid therapy;

(d) The medical record did not include adequate information on the reasons for continuing to prescribe high dose opioids or the reasons for increasing or decreasing dosage;

(e) The Respondent frequently prescribed opioids with highly abusable medications such as benzodiazepines;[2] and

(f) The Respondent did not adequately follow appropriate guidelines to prevent narcotic diversion and abuse, such as regular urine or blood toxicology screenings, pain contracts, and did not regularly monitor drug databases.

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[1] The term opioid therapy is used to describe medical treatment with drugs that are derived from the opioid alkaloids found in the opium poppy plant as well as many synthetic chemical derivatives. Medications in this class, which are used to treat moderate to severe pain, include Morphine, Codeine, Hydromorphone, Oxycodone, Hydrocodone, and Methadone.

[2] Benzodiazepines are a class of medications, called depressants, used to produce sedation, induce sleep, relieve anxiety, and muscle spasms.

IV. PATIENT-SPECIFIC ALLEGATIONS

9. Examples of the above investigative findings are set forth in the following patient-specific findings. These summaries are not intended as, and do not represent, a complete description of the evidence with respect to the Respondent's conduct in this matter.

Patient One[3]

10. Beginning in 2000, the Respondent provided care, for almost nineteen years, to Patient One a female in her late sixties[4] with chronic medical problems, including obesity, hypertension, depression, and chronic back pain.

11. The Respondent managed Patient One's depression with multiple anti-depressant medications, including Paxil, Effexor, Remeron, Cymbalta, Abilify, Wellbutrin, and Lexapro, over almost a nineteen-year period. The Respondent prescribed Klonopin[5] for anxiety, and various drugs such as, Ambien,[6] trazodone,[7] and temazepam [8] for insomnia. The Respondent also prescribed Soma[9] and hydrocodone/acetaminophen

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[3] For confidentiality purposes, the names of all individuals, medical facilities and/or other agencies referenced herein will not be identified by name in this document.

[4] The approximate age of Patient One and the other patients is based on the Patients' age when the record was reviewed by the peer reviewers in 2019.

[5] Klonopin is a benzodiazepine, a class of depressants that produce sedation, induce sleep, relieve anxiety, and muscle spasms, and prevent seizures.

[6] Ambien is a sedative used to treat insomnia.

[7] Trazodone is an antidepressant that belongs to a group of drugs called selective serotonin reuptake inhibitors (SSRIs). It affects chemicals in the brain that may be unbalanced in people with depression.

[8] Temazepam is a medication used on a short-term basis to treat insomnia (difficulty falling asleep or staying asleep). Temazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow sleep. Temazepam in combination with opiates, alcohol and certain other drugs can cause serious respiratory problems.

[9] Soma (carisoprodol) is a muscle relaxant used with rest, physical therapy, and other measures to relax muscles and relieve pain and discomfort caused by strains, sprains, and other muscle injuries.

(Norco)[10] for back pain. The Respondent also prescribed Patient One phentermine and phendimetrazine to manage obesity.

12. On January 7, 2016, during an office visit the Respondent prescribed Patient One hydrocodone/acetaminophen 10/325 #120 (up to 6/day). The Respondent continued to routinely prescribe hydrocodone/acetaminophen 10/325 #120 (up to 6/day). The Respondent also prescribed clonazepam[11] 0.5 milligrams (mg) at bedtime.

13. On December 6, 2018, the Respondent prescribed hydrocodone/ acetaminophen 10/325 #120 (up to 6/day) and clonazepam 0.5 milligrams (mg) at bedtime. This same prescribing pattern continued for an almost nineteen-year period.

14. In December 2018, Patient One was hospitalized with dehydration and mental confusion and was diagnosed with a lumbar compression fracture.

15. The Respondent performed one documented drug screening for Patient One in 2016, and two Prescription Drug Monitoring Program (PDMP)[12] queries on June 26, 2018, and August 8, 2018.

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[10] Hydrocodone/acetaminophen s an opioid pain medication, sometimes called a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone. Acetaminophen and hydrocodone are a combination medicine used to relieve moderate to severe pain.

[11] Clonazepam is a benzodiazepine that works by enhancing the activity of certain neurotransmitters in the brain. It is used to treat seizure disorders and anxiety.

[12] The Prescription Drug Monitoring Program (PDMP) collects and securely stores information on drugs that contain controlled substances and are dispensed to patients in Maryland. Drug dispensers, including pharmacies and healthcare practitioners, electronically report the information that is stored in the PDMP database.

16. The Respondent failed to discuss with Patient One the known benefits and risks of opioid therapy and failed to obtain adequate informed consent for opioid therapy.

17. The Respondent treated Patient One with dual benzodiazepines (temazepam and Klonopin) in addition to hydrocodone/acetaminophen 10/325 and Soma (carisoprodol), which metabolized into meprobamate, a barbiturate-like sedative, which is also known to be habit forming and a respiratory depressant. The patient is on four medications, which can cause withdrawal symptoms and death if abruptly discontinued.

18. The peer reviewers agreed that the Respondent did not meet the appropriate standard of care for the delivery of quality medical care while treating Patient One for a number of reasons, including but not limited to the following:

(a) The medical record did not include baseline drug screening evaluation;

(b) The Respondent failed to discuss with patient the known risks and benefits of opioid therapy;

(c) The Respondent failed to obtain adequate patient informed consent for opioid therapy;

(d) The medical record does not include adequate information on the reasons for continuing to prescribe high dose opioids;

(e) The Respondent frequently prescribed opioids with highly abusable medications such as benzodiazepines and Soma; and

(f) The Respondent does not adequately follow appropriate guidelines to prevent narcotic diversion and abuse such as, pill counts,

toxicology screening, regular pharmacy checks and regular urine drug tests;

Patient Two

19. The Respondent provided treatment for Patient Two from approximately 2014 through 2019. Patient Two is a female in her late forties with chronic medical problems, including hypertension,[13] bronchitis[14] and peripheral neuropathy,[15] migraine headaches, anxiety, back pain, and fibromyalgia[16]. Patient Two had lumbar spine surgery in 2015.

20. Patient Two had a history of gastric-bypass surgery[17] with GERD,[18] and a motor vehicle accident, which caused chest pain. Patient Two was treated with increasing

[13] Hypertension (high blood pressure) is the product of the flow of the blood times the resistance in the blood vessels. Blood pressure is measured with a blood pressure cuff and recorded as two numbers, such as 120/80 mm Hg (millimeters of mercury). Individuals with blood pressure consistently above the norm are diagnosed with high blood pressure. High blood pressure can lead to heart disease and other serious health complications.

[14] Bronchitis is an inflammation of the lining of the bronchial tubes, which carry air to and from the lungs. People who have bronchitis often cough up thickened mucus, which can be discolored. Bronchitis may be either acute or chronic.

[15] Peripheral neuropathy is a condition caused by damage to the nerves outside of the brain and spinal cord (peripheral nerves), it often causes weakness, numbness, and pain, usually in the hands and feet. It can also affect other areas of the body.

[16] Fibromyalgia is a condition that causes pain all over the body (also referred to as widespread pain), sleep problems, fatigue, and often emotional and mental distress.

[17] Gastric-bypass surgery refers to a surgical process in which the stomach is divided into a small upper pouch and a much larger lower "remnant" pouch and then the small intestine is rearranged to connect to both. The procedure leads to a marked reduction in the functional volume of the stomach, accompanied by an altered physiological and physical response to food.

[18] Gastroesophageal reflux disease (GERD) occurs when stomach acid frequently flows back into the tube connecting the mouth and stomach (esophagus). This backwash (acid reflux) can irritate the lining of the esophagus.

doses of hydrocodone/acetaminophen 10/325 mgs 3/day up to 6/day, Soma, Xanax, and Halcion.[19]

21. On January 5, 2016, The Respondent saw Patient Two for an office visit, for treatment of back pain, peripheral neuropathy, and migraine headaches. She also complained of neck pain and was diagnosed with lupus erythematosus.[20]

22. On January 5, 2016, the Respondent prescribed Patient Two hydrocodone/ acetaminophen 10/325 #120 (up to 6/day) and Alprazolam[21] 0.5 milligrams. The Respondent continued to routinely prescribe these medications for Patient Two.

23. On February 28, 2019, during an office visit the Respondent noted that Patient Two was prescribed Xanax[22] 2mg 3/day; Soma 250 mg 4/day; Halcion 0.25 3/bedtime; Ambien 12.5; and hydrocodone/acetaminophen 10/325. The Respondent noted in the record that he recommended that Patient Two choose only one medication for insomnia. He also informed Patient Two that she was taking a dose of Halcion above the manufacturer recommended dose but continued to prescribe this dosage.

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[19] Halcion (triazolam)is a potent benzodiazepine prescribed to treat mental, mood, and other disorders, including insomnia, and anxiety.

[20] Lupus erythematosus or systemic lupus erythematosus (SLE) is a chronic disease that causes inflammation in connective tissues, such as cartilage and the lining of blood vessels, which provide strength and flexibility to structures throughout the body. The signs and symptoms of SLE vary among affected individuals, and can involve many organs and systems, including the skin, joints, kidneys, lungs, central nervous system, and blood-forming (hematopoietic) system.

[21] Alprazolam is used to treat anxiety and panic disorders. It belongs to a class of medications called benzodiazepines which act on the brain and nerves (central nervous system) to produce a calming effect. It works by enhancing the effects of a certain natural chemical in the body (GABA).

[22] Xanax is a benzodiazepine that is used to treat anxiety.

24. The Respondent documented only three PDMP queries on September 28, 2017, November 1, 2017, and July 23, 2018. The medical record does not contain any documented urine drug screen reports.

25. The Respondent treated Patient Two with dual benzodiazepines (Xanax and Halcion) and hydrocodone/acetaminophen 10/325 and Soma (carisoprodol), which metabolized into meprobamate, a barbiturate-like sedative, which is also known to be habit forming and a respiratory depressant. The patient is on four medications, which can cause withdrawal symptoms and death if abruptly discontinued.

26. The medical record also indicates that Patient Two was receiving narcotics from another provider. The medical record does not indicate that the Respondent appropriately addressed the fact that Patient Two was receiving narcotics from another provider.

27. The Respondent failed to discuss with Patient Two the known benefits and risks of opioid therapy and failed to obtain adequate informed consent for opioid therapy.

28. The peer reviewers found that the Respondent did not meet the appropriate standard of care for the delivery of quality medical care while treating Patient Two for a number of reasons, included but not limited to the following:

(a) The medical record did not include baseline drug screening evaluation;

(b) The Respondent failed to discuss with Patient the known risks and benefits of opioid therapy;

(c) The Respondent failed to obtain adequate informed patient consent for opioid therapy;

(d) The medical record does not include adequate information on the reasons for continuing to prescribe high dose opioids;

(e) The Respondent frequently prescribed opioids with highly abusable medications like benzodiazepines and Soma; and

(f) The Respondent inappropriately prescribed Soma for long periods of time; and

(g) The Respondent did not adequately monitor for abuse and/or diversion of narcotics, with regular urine screening, blood toxicology tests, pill counts, or regular pharmacy checks.

Patient Four

29. From 2015 through 2019, the Respondent provided care to a female in her early thirties with chronic neck, right shoulder, and bilateral feet pain. The Respondent saw Patient Four for an office visit on January 20, 2016, and prescribed hydrocodone/acetaminophen 10/325 #120 (up to 6/day) and Alprazolam 2 mg/3day. The Respondent continued the same prescribing pattern for Patient Four for several years.

30. On June 28, 2016, the Respondent prescribed Patient Four hydrocodone/acetaminophen 10/325 #120 (up to 6/day) and Alprazolam 2 mg/3day. This prescribing pattern continued. Patient Four was referred to orthopedics and physical therapy, but the record does not include any imaging studies to document the cause of the patient's pain.

31. The medical record contains three PDMP queries and one documented urine drug screen report on June 8, 2016. Patient Four tested positive for non-prescribed benzodiazepines and was receiving drugs from multiple providers. Patient Four also tested negative for prescribed opioids. There is no indication that there was appropriate follow-up on the positive drug screen, except Patient Four was prescribed Buspar[23] to wean the patient off benzodiazepines. The Respondent continued to prescribe hydrocodone/acetaminophen 10/325 #120 (up to 6/day) and Alprazolam 2 mg/3day.

32. The Respondent failed to discuss with Patient Four the known benefits and risks of opioid therapy and failed to obtain adequate informed consent for opioid therapy.

33. The peer reviewers found that the Respondent did not meet the appropriate standard of care for providing quality medical care while treating Patient Four for a number of reasons, included but not limited to the following:

(a) The medical record did not include baseline drug screening evaluation;

(b) The Respondent failed to discuss with the patient the known risks and benefits of opioid therapy;

(c) The Respondent failed to obtain adequate informed patient consent for opioid therapy;

[23] Buspar (Buspirone) is an anti-anxiety medicine that affects chemicals in the brain that may be unbalanced in people with anxiety. Buspirone is used to treat symptoms of anxiety, such as fear, tension, irritability, dizziness, pounding heartbeat, and other physical symptoms.

(d) The medical record does not include adequate information on the reasons for continuing to prescribe high dose opioids;

(e) The Respondent frequently prescribed opioids with highly abusable medications like benzodiazepines; and

(f) The Respondent did not adequately monitor for abuse and/or diversion of narcotics, with regular urine screening, blood toxicology tests, pill counts, or regular pharmacy checks.

Patient Five

34. The Respondent began seeing Patient Five briefly in 2004; Patient 5 returned to the practice in 2016. Patient Five is a female in her mid-sixties with chronic medical problems, including hypertension, asthma, and depression. Over a period of two years. the Respondent prescribed multiple medications to treat pain, depression, and anxiety, including hydrocodone/acetaminophen 10/325; Soma; gabapentin;[24] Klonopin, Ambien, Xanax, Wellbutrin,[25] and temazepam.

35. The Respondent saw Patient Five for back pain during an office visit on June 27, 2016. On that date the Respondent prescribed hydrocodone/ibuprofen 7.5/200 mg up to 12 tabs/day.

[24] Gabapentin is used with other medications to prevent and control seizures. It is also used to relieve nerve pain.. Gabapentin is known as an anticonvulsant or antiepileptic drug.

[25] Wellbutrin (bupropion) is an antidepressant medication used to treat major depressive disorder and seasonal affective disorder.

36. The Respondent saw Patient Five on July 26, 2016, and on that date the Respondent prescribed hydrocodone/acetaminophen 10/325 (up to 6/day) and clonazepam 1mg QHS.[26]

37. On August 17, 2017, the Respondent saw Patient Five during an office visit and prescribed Norco (hydrocodone/acetaminophen) 10/325 (up to 12/day); Soma 350 mg; temazepam 15 mg 1/bedtime; and Klonopin 0.5 mg 1/bedtime.

38. On April 17, 2018, Patient Five was hospitalized for mental confusion and falls and diagnosed with an accidental medication overdose.

39. On August 15, 2018, the Respondent saw Patient Five for an office visit and prescribed hydrocodone/acetaminophen 10/325 (up to 12/day) and clonazepam 1mg QHS, Wellbutrin and Soma.

40. In August of 2018, the Respondent received a complaint from a relative that Patient Five was abusing narcotics with alcohol. Patient Five was later discharged from the practice.

41. The Respondent performed one urine drug screening on May 31, 2016, and PDMP queries on October 19, 2017, July 17, 2018, and August 15, 2018. PDMP inquiries revealed that Patient Five was receiving narcotics from multiple providers.

42. The Respondent treated the patient with dual benzodiazepines (Klonopin and temazepam) and hydrocodone/acetaminophen 10/325 and Soma (carisoprodol), which metabolized into meprobamate, a barbiturate-like sedative, which is also known to be habit

[26] QHS is the medical abbreviation at bedtime.

forming and a respiratory depressant. The patient is on several medications, which can cause withdrawal symptoms and death if abruptly discontinued.

43. The Respondent failed to discuss with Patient Five the known benefits and risks of opioid therapy, and failed to obtain informed consent for opioid therapy

44. The peer reviewers found that the Respondent did not meet the appropriate standard of care for the delivery of quality medical care while treating Patient Five for a number of reasons, included but not limited to the following:

(a) The medical record did not include baseline drug screening evaluation;

(b) The Respondent failed to discuss with patient the known risks and benefits of opioid therapy;

(c) The Respondent failed to obtain adequate informed patient consent for opioid therapy;

(d) The Respondent frequently prescribed opioids with highly abusable medications like benzodiazepines and Soma;

(e) The medical record does not include adequate information on the reasons for continuing to prescribe high dose opioids; and

(f) The Respondent did not adequately monitor for abuse and/or diversion of narcotics, with urine screening, blood toxicology tests, pill counts, or pharmacy checks.

Patient Seven

45. The Respondent provided care to, Patient Seven, a man in his late forties diagnosed with morbid obesity, obstructive sleep apnea,[27] bilateral knee pain, and underlying osteoarthritis. The Respondent treated Patient Seven with hydrocodone/acetaminophen 10/325, but the Respondent also prescribed increasing doses of benzodiazepines (i.e., up to 8 mg of Alprazolam per day).

46. On February 3, 2016, the Respondent saw Patient Seven for an office visit for chronic pain and hypercholesterolemia.[28] On that day the Respondent prescribed hydrocodone/acetaminophen 10/325 and Alprazolam 2mg/2day. The Respondent maintained the same prescribing pattern for several years, except the Alprazolam was increased over time.

47. On January 9, 2019, the Respondent saw Patient Seven for an office visit, and prescribed hydrocodone/acetaminophen 10/325 (up to 6/day) and Alprazolam 2mg/2day.

48. For the period of February 2015 through March 2019, the Respondent performed one urine drug screening in March of 2019. The screening was positive for Fentanyl, which was not prescribed and negative for the benzodiazepines which were

[27] Obstructive Sleep Apnea (OSA) is a condition in which breathing stops involuntarily for brief periods of time during sleep. Normally, air flows smoothly from the mouth and nose into the lungs at all times. Periods when breathing stops are called apnea or apneic episodes. In OSA, the normal flow of air is repeatedly stopped throughout the night. The flow of air stops because airway space in the area of the throat is too narrow. Snoring is characteristic of obstructive sleep apnea. Snoring is caused by airflow squeezing through the narrowed airway space.

[28] Hypercholesterolemia is also called high cholesterol, is the presence of high levels of cholesterol in the blood. It is a form of hyperlipidemia, high blood lipids, and hyperlipoproteinemia (elevated levels of lipoproteins in the blood).

prescribed. The Respondent failed to do appropriate follow-up on the aberrant drug screening test.

49. The Respondent performed three PDMP drug screenings on October 25, 2017, July 11, 2018, and August 13, 2018.

50. The Respondent failed to discuss with Patient Seven the known benefits and risks of opioid therapy and failed to obtain adequate informed consent for opioid therapy.

51. The Respondent routinely prescribed opioids and benzodiazepines together for Patient Seven.

52. The peer reviewers found that the Respondent did not meet the appropriate standard of care for the delivery of quality medical care while treating Patient Seven for a number of reasons, included but not limited to the following:

(a) The medical record did not include baseline drug screening evaluation;

(b) The Respondent failed to discuss with the patient the known risks and benefits of opioid therapy;

(c) The Respondent failed to obtain adequate informed patient consent for opioid therapy;

(d) The Respondent frequently prescribed opioids with highly abusable medications like benzodiazepines;

(e) The medical record does not include adequate information on the reasons for continuing to prescribe opioids; and

(f) The Respondent did not adequately monitor for abuse and/or diversion of narcotics, with regular urine screening, blood toxicology tests, pill counts, or regular pharmacy checks.

CONCLUSION OF LAW

Based on the Findings of Fact, Disciplinary Panel A of the Board concludes as a matter of law that the Respondent's conduct constitutes a failure to meet the standard of care for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22).

ORDER

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

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

ORDERED that the Respondent is **PERMANENTLY PROHIBITED** from prescribing and dispensing all Controlled Dangerous Substances (CDS) under Criminal Law § 5-401 et seq.; and it is further

ORDERED that the Respondent is **PERMANENTLY PROHIBITED** from certifying patients for the medical use of cannabis; and it is further

ORDERED that on every January 31st thereafter if the Respondent holds a Maryland medical license, the Respondent shall provide the Board with an affidavit verifying that he has not prescribed any of the prohibited CDS and has not certified patients for Cannabis in the past year; and it is further

ORDERED that if the Respondent fails to provide the required annual verification of compliance with this condition:

(1) there is a presumption that the Respondent has violated the permanent condition; and

(2) the alleged violation will be adjudicated pursuant to the procedures of a Show Cause Hearing.

ORDERED that disciplinary panel may issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program on a quarterly basis for the Respondent's Controlled Dangerous Substances ("CDS") prescriptions. The administrative subpoenas will request the Respondent's CDS prescriptions from the beginning of each quarter.

ORDERED that the Respondent is placed on **PROBATION** for a minimum of **ONE YEAR.**[29]

ORDERED that the Respondent shall not apply for early termination of probation; and it is further

ORDERED that, after the Respondent has complied with all terms and conditions of probation and the minimum period of probation imposed by the Consent Order has passed, the Respondent may submit a written petition for termination of probation. After consideration of the petition, the Respondent's probation may be administratively terminated through an order of the disciplinary panel if the Respondent has complied with all probationary terms and conditions and there are no pending complaints relating to the charges; and it is further

[29] If Dr. Pritchett's license expires while Dr. Pritchett is on probation, the probationary period and any probationary conditions will be tolled.

ORDERED that the effective date of the Consent Order is the date the Consent Order is signed by the Executive Director of the Board or her designee. The Executive Director or her designee signs the Consent Order on behalf of the disciplinary panel which has imposed the terms and conditions of this Consent Order; 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, if the Respondent allegedly fails to comply with any term or condition imposed by this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If the disciplinary panel determines there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings followed by an exceptions process before a disciplinary panel; and if the disciplinary panel determines there is no genuine dispute as to material fact, the Respondent shall be given a show cause hearing before a disciplinary panel; and it is further

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

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

ORDERED that this Consent Order is a public document. See Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6); and it is further

10/23/2020
Date

Signature on File

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians

CONSENT

I, Paul E. Pritchett, Sr., M.D., acknowledge that I have consulted with counsel before signing this document.

By this Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition.

I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 14-405 and Md. Code Ann., State Gov't §§ 10-201 *et seq.* concerning the pending charges. I waive this right and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability of this Consent Order as if entered 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 behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive protections. I acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order.

I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.

I sign this Consent Order, without reservation, and fully understand the language and meaning of its terms.

Signature on File

10-22-20
Date

Paul E. Pritchett, Sr., M.D.

NOTARY

STATE OF Maryland

CITY/COUNTY OF Charles

I HEREBY CERTIFY that on this 22 day of October 2020, before me, a Notary Public of the foregoing State and City/County, personally appeared Paul E. Pritchett, Sr., M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

Kayla Cooksey

Notary Public

KAYLA COOKSEY
Charles County
My Commission Expires
July 31, 2023

My Commission expires: _____