IN THE MATTER OF	*	**BEFORE THE**
STEPHEN R. SMITH, M.D.	*	**MARYLAND STATE**
Respondent.	*	**BOARD OF PHYSICIANS**
License Number: D14957	*	**Case Number: 7720-0045**

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FINAL DECISION AND ORDER

INTRODUCTION

On November 13, 2020, Disciplinary Panel A of the Maryland State Board of Physicians ("Board") charged Stephen R. Smith, M.D., with unprofessional conduct in the practice of medicine, willfully making or filing a false report or record in the practice of medicine, failing to cooperate with a lawful investigation by the Board, under Md. Code Ann., Health Occ. § 14-404(a)(3)(ii), (11), and (33), respectively, and with violating the Board's sexual misconduct regulations, COMAR 10.32.17.03, promulgated under Health Occ. § 1-212(a). The charges alleged that Dr. Smith inappropriately treated his family members for long term conditions, made false statements to investigators, and committed significant boundary violations and sexual misconduct by having a sexual relationship with Patient B.[1]

After a one-day remote hearing before an Administrative Law Judge ("ALJ") at the Office of Administrative Hearings ("OAH"), on June 8, 2021, the ALJ issued a proposed decision. The ALJ concluded that Dr. Smith was guilty of unprofessional conduct in the practice of medicine, violated the Board's sexual misconduct regulations, willfully made or filed a false report or record in the practice of medicine, and failed to cooperate with a lawful investigation. The ALJ recommended revocation of Dr. Smith's license.

[1] For purposes of confidentiality, the Board will not disclose patient names or the names and type of relationship of family members.

On September 17, 2021, Dr. Smith filed written exceptions to the ALJ's Proposed Decision. On October 5, 2021, the State filed a response to Dr. Smith's exceptions. On November 17, 2021, Board Disciplinary Panel B ("the Panel" or "Panel B") heard oral arguments on Dr. Smith's exceptions.

FINDINGS OF FACT

Panel B adopts the ALJ's Proposed Findings of Fact. The ALJ's Proposed Findings of Fact (paragraphs 1-33) are incorporated by reference into the body of this document as if set forth in full. *See* attached ALJ Proposed Decision, Exhibit 1. The factual findings were proven by a preponderance of the evidence. The Panel also adopts the ALJ's discussion set forth on pages 9-32 of the ALJ's proposed decision. The findings of facts are summarized below:

Dr. Smith is an endocrinologist originally licensed to practice in Maryland in 1973. Dr. Smith treated Family Member 1 numerous times and not only in emergency situations. Specifically, he prescribed medication to Family Member 1 for allergies, outside his expertise, in anticipation of Family Member 1's travel. Dr. Smith treated Family Member 2 for diabetes and hypertension which are chronic problems of long-term duration.

In 1998, Dr. Smith began to treat Patient B for hypothyroidism. Dr. Smith was informed of Patient B's mental health history, including post-traumatic stress disorder ("PTSD") and depression and he also knew about a prior abusive relationship. Dr. Smith and Patient B began a relationship outside the office that became sexually intimate starting in 2005 for several years while Patient B remained a patient. Dr. Smith stopped keeping medical records for Patient B in 2005, but continued to write Patient B refill prescriptions. In 2013, Dr. Smith "thinned" the patient file, claiming that it had become too thick.

In 2009, Dr. Smith treated Family Member 3[2] for a serious medical condition that was outside his area of expertise, including prescribing and refilling medications. He also prescribed medications for potential conditions such as malaria, diarrhea, and motion-sickness when she travelled.

In 2017 and 2018, Dr. Smith saw Patient A fifteen times for chronic pain and anxiety. Dr. Smith prescribed Patient A oxycodone and benzodiazepines without obtaining her past medical records. At some point he began a relationship with Patient A that involved some sexual intimacy, but no sexual intercourse. The Board learned of this relationship from Dr. Smith as part of an investigation that stemmed from three complaints, in 2018, related to Dr. Smith's prescribing. As part of that investigation, Board staff asked Dr. Smith if he had any kind of personal relationship with any other patient, and Dr. Smith falsely answered "No, mmh-mmh."

Based on standard of care and recordkeeping pertaining to Dr. Smith's prescribing of Controlled Dangerous Substances (CDS) to several patients including Patient A and his sexual relationship with Patient A, the Board and Dr. Smith entered into a Consent Order in 2019 in which Dr. Smith was reprimanded, permanently prohibited from prescribing CDS, placed on probation for a year with a referral to the Maryland Professional Rehabilitation Program (MPRP), and required to take courses in boundaries and recordkeeping. MPRP referred Dr. Smith to an assessment program (the "Program") for a fitness-for-duty evaluation. As part of the evaluation, Dr. Smith was asked questions related to his treatment of family members and his sexual relationship with patients. Dr. Smith informed the Program that he had provided medical care and prescribed medications for his family members and that he had a sexual relationship while treating Patient B, information that he failed to disclose to the Board during its previous investigation. The Board requested a written response to his new disclosure that he had a sexual

[2] This person was in a close quasi-family relationship with Dr. Smith.

relationship while treating Patient B, which Dr. Smith provided. Thereafter the Board opened an investigation and subpoenaed Patient B's medical records. After completing the investigation, on November 13, 2020, Panel A issued charges.

EXCEPTIONS

Dr. Smith raises five arguments in his exceptions. Dr. Smith argues that: (1) the State did not provide adequate notice of the allegations against him; (2) the AMA Opinion 8.19 does not prohibit prescribing to family members in situations such as this; (3) Patient B was a former patient and there is no prohibition on sexual relationships with former patients; (4) he did not mislead the Board when he answered that he had not had a sexual relationship with patients whom he was treating; and (5) the Program deemed him fit to practice, so the Board should allow him to continue to practice medicine.

1. The State's Notice was Adequate.

Dr. Smith first argues that the State failed to give sufficient notice of the allegations against him prior to the hearing. Dr. Smith states that at the OAH hearing, the State referenced "unrelated prior interactions with the Board that did not result in charges." Dr. Smith does not specifically describe what interactions he is referring to, but the State's response explains that he appears to be referring to the State's expert's testimony about two instances where Dr. Smith was investigated and received advisory letters, but was not charged with violating the Medical Practice Act. Dr. Smith also argues that he was not given sufficient notice related to his treatment of Patient B's husband while he was having a sexual relationship with Patient B.[3]

First, Dr. Smith has waived these arguments because he did not object to the discussion of the advisory letters or his treatment of Patient B's husband at OAH. "If a party fails to object,

[3] The State did not raise this issue in its case in chief, rather this was information provided by Dr. Smith during cross-examination by the State.

'he will not later be heard to complain that the evidence should not have been admitted.'" *Rosov v. Maryland State Bd. of Dental Exam'rs*, 163 Md. App. 98, 112 (2005) (quoting *Ginn v. Farley*, 43 Md. App. 229, 236-37 (1979)). *See also Swoboda v. Wilder*, 173 Md. App. 615, 641 (2007) ("the Protestants did not object to the testimony of [the witness] and therefore waived their objection to the Board's consideration of it"); Maryland Rule 4-323 ("An objection to the admission of evidence shall be made at the time the evidence is offered or as soon thereafter as the grounds for objection become apparent. Otherwise the objection is waived."). Based on Dr. Smith's failure to object during the hearing at OAH, the Panel finds that he has waived any claims regarding insufficient notice regarding the advisory letters and the testimony regarding treatment of Patient B's husband.

Even if the Panel considered these arguments, the Panel would find that the State complied with the necessary requirements for notice. The standards for notice are set forth in State Gov't § 10-207, which states that an "agency shall give reasonable notice of the agency's action," and the notice shall, among other things "state concisely and simply the facts that are asserted" or "the issues that are involved." State Gov't § 10-207(a)(b)(1)(i) & (ii). In *Reed v. Baltimore*, 323 Md. 175, 184 (1991), the Court held that the notice requirement should be "in sufficient detail to enable the [party] to marshal evidence and arguments in defense of the assertions." In *Regan v. Board of Chiropractic Examiners*, 355 Md. 397, 420 (1997), the Court of Appeals explained that the "gist of the charges" has to mirror the "gist of the Board's findings."

Here, the Board's finding of a violation is not based on the advisory letters and the treatment of Patient B's husband. Rather, Dr. Smith was found in violation due to his prescribing to family members, his sexual relationship with Patient B, and his false statement

that he had not previously had a sexual relationship with any other patients. The advisory letter and the related allegations were only mentioned in the ALJ's proposed decision in the summary of the State's expert's testimony and never discussed again. Similarly, Dr. Smith's statement during cross-examination that he treated Patient B's husband only merited a passing mention in a summary of Dr. Smith's testimony, and was not the basis for the ALJ's proposed findings. None of these facts formed the basis for any of the ALJ's proposed findings of fact, analysis, or sanction sections, and they are not considered in the Panel's analysis in this Order.

The central thrust or "gist" of the ALJ's analysis below and the Panel's analysis herein concerns Dr. Smith's treatment of family members, his sexual relationship with Patient B, and the false statements he made during his Board interview. Certainly, the "gist" of the Panel's findings reflect the "gist" of charges. *See Regan*, 355 Md. at 420. Dr. Smith has been given more than sufficient notice to be able to marshal a defense on those grounds. *Reed*, 323 Md. at 177. The Panel, therefore, denies Dr. Smith's exception regarding insufficient notice.

2. Dr. Smith Inappropriately Prescribed to Family Members.

Dr. Smith treated three family members, one inside his field of expertise and two outside his practice specialty. 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. Smith's conduct was unprofessional.

Ethics Opinion 1.2.1 states "[i]n general, physicians should not treat . . . members of their own families." The opinion notes that physicians may treat family members "[i]n emergency

settings or isolated settings where there is no other qualified physician available" and for "short term, minor problems." Particularly relevant here, the opinion discussed how physicians "may also be inclined to treat problems that are beyond their expertise or training."

In his exception, Dr. Smith argues that there is no total prohibition for prescribing to family members and that AMA Opinion 8.19 provides circumstances where physicians may care for family members. Dr. Smith claims that he cared for his family members in limited circumstances, such as overseas travel, and that he caused them no harm.

The ALJ found, however, and the Panel agrees, that Dr. Smith treated his family outside of the AMA's limited permissible exceptions for treating family members.

Family Member 1 had an allergic reaction, which Dr. Smith believed was a food allergy. Rather than have her assessed by an allergist, Dr. Smith routinely prescribed allergy medications prior to travel and Family Member 1 depended on Dr. Smith to provide the medication. Dr. Smith's treatment of Family Member 1 was not an emergency situation or for a short-term problem and his treatment was outside Dr. Smith's medical expertise.

Dr. Smith also routinely treated Family Member 2 for diabetes and hypertension, which are chronic problems of long-term duration, not short-term, minor problems.

Finally, Dr. Smith treated Family Member 3 outside his area of expertise for a serious medical condition by renewing Family Member 3's prescriptions that had previously been prescribed by Family Member 3's physician. He also prescribed travel medications (such as for prevention of malaria or traveler's diarrhea) for Family Member 3 that could have been prescribed by a primary care physician.

Because he routinely prescribed to his family members outside his expertise and treated chronic conditions, the Panel finds that the ALJ correctly determined that his treatment of family

members went beyond the limited exceptions provided in the AMA opinions, and, therefore, was unethical and unprofessional conduct. Dr. Smith's exception is denied.

3. Dr. Smith had an Inappropriate Sexual Relationship with a Patient.

Sexual relationships with patients are both unprofessional and considered sexual misconduct under the Board's sexual misconduct regulations. At the time of the sexual relationship, the Board's regulations stated that licensees "may not engage in sexual misconduct," COMAR 10.32.17.03, and that Health Occ. § 14-404(b)(3) (immoral or unprofessional conduct) "includes, but is not limited to, sexual misconduct." Under COMAR 10.32.17.02B(3)(c) sexual misconduct was defined as including "[e]ngaging in a dating, romantic, or sexual relationship which violates the code of ethics of the American Medical Association."

The State's expert considered AMA Ethics Opinion 9.1.1 related to romantic or sexual interactions with patients. Opinion 9.1.1 states that romantic or sexual interactions between physician and a patient are unethical because they "detract from the goals of the patient-physician relationship and may exploit the vulnerability of the patient . . . and ultimately be detrimental to the patient's well-being."

Dr. Smith argued that the AMA Code of Medical Ethics 9.1.1 prohibits relationships with "concurrent" patients, but not former patients. Dr. Smith claimed that his relationship with Patient B began after he last saw her as a patient and that her last visit was a "line in the sand" and that he began to socialize with Patient B a month, two or three after the end of the professional relationship. He explained that he did not issue a cessation of practice discharge letter because he was only acting as a consultant.

The ALJ did not believe Dr. Smith's claim that the relationship had ended before his personal and sexual relationship began. Neither does the Panel. The Panel finds that Dr. Smith began treating Patient B in 1998, began a sexual relationship with Patient B in 2005, and that his sexual relationship and the physician-patient relationship overlapped. The documentary evidence, Dr. Smith's own testimony, and Dr. Smith's prior statements to the Program and subsequent letter to the Board indicate that the sexual relationship was concurrent with his treatment of Patient B.

Regarding the documentary evidence, Dr. Smith never issued a discharge letter to Patient B and Dr. Smith's medical records from Patient B's last visit indicated an intent that she would return for care for a follow-up visit to review laboratory test results. Nothing in the records suggested that her treatment ended. Further, the medical records were incomplete because, in 2013, Dr. Smith "thinned" his file.

Dr. Smith himself testified that he refilled prescriptions for long term therapies for Patient B even after their sexual relationship began.

Dr. Smith's claim that his professional relationship with Patient B ended prior to the sexual relationship was also inconsistent with his prior statements to the Program. In his interview with the Program on March 4, 2020, Dr. Smith admitted that his sexual relationship began in "2005 and continued until 2007 while she was still a patient of his." In a letter, dated August 20, 2020, the Board sought additional clarification from Dr. Smith regarding the relationship. On August 27, 2020, Dr. Smith sent a response letter to the Board where he claimed that the social friendship began shortly after 2000, and then five years later became "an occasional intimate relationship that extended over two years. . . . I continued to see her occasionally as a patient thereafter."

Dr. Smith has since disclaimed his prior statement to the Program and to the Board, claiming that he made "the same misstatement in two different places." Dr. Smith's excuse is that he did not review the records before his meeting with the Program, so had not been able to check when the sexual relationship ended. However, this excuse does not explain why he made the same statement admitting to the overlapping sexual relationship and medical treatment in his letter to the Board that was written when he could review his records. The Panel rejects this self-serving claim that the prior statements were misstatements. Dr. Smith's version of events only changed after he was charged and thereby informed that such relationships were unethical and a potential violation of the Medical Practice Act. The Panel adopts the ALJ's conclusion that Dr. Smith's treatment of Patient B overlapped with their sexual relationship. Dr. Smith's exception is denied.

4. Dr. Smith's Statement to the Board Investigators was False.

The remaining charges of making a false report and a failure to cooperate with the Board's investigation concern Dr. Smith's false answer to the question asked during his Board interview related to his sexual relationship with Patient A. When asked "Did you ever have any kind of personal relationship with any other patients that you were treating?" Dr. Smith stated: "No." This answer was later discovered to be false because, as discussed above, Dr. Smith admitted that he treated Patient B during his sexual relationship with her.

Dr. Smith argues in his exceptions that he did not have a sexual relationship concurrent with his treatment of Patient B and therefore his statement to the investigators was correct. As discussed above, the Panel finds that his sexual relationship did overlap with the patient-physician relationship and this answer was, therefore, incorrect and untruthful.

The Panel further notes that this misstatement was not based on Dr. Smith's mistaken belief that the relationship was concurrent. When first asked about why he answered that he had not had a personal relationship with a patient he was treating, Dr. Smith explained that he "was in the mindset of the contemporary period. [Dr. Smith's] relationship with [Patient B] was 13-15 years ago." This is clearly not what the investigator was asking when she asked "Did you ***ever*** have" such a relationship. At the hearing and exceptions, Dr. Smith changed his answer, and now claims that he never had a concurrent sexual and patient relationship, because the patient relationship had ended. The Panel does not believe Dr. Smith's new explanation. The Panel concludes that Dr. Smith intentionally withheld the prior overlapping sexual relationships and patient relationships, which includes both his relationship with Patient B, but also his treatment of his family members, to avoid a harsher sanction.

CONCLUSIONS OF LAW

Panel B concludes that Dr. Smith is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii), for providing medical treatment to his family members and also based on his sexual relationship with Patient B. Panel B concludes that his sexual relationship with Patient B also violated the Board's sexual misconduct relegations, under COMAR 10.32.17.03. Panel B concludes that Dr. Smith is guilty of willfully making or filing a false report in the practice of medicine, in violation of Health Occ. § 14-404(a)(11), and failing to cooperate with a lawful investigation conducted by the Board or a disciplinary panel, in violation of Health Occ. § 14-404(a)(33), for falsely stating that he had not had a prior sexual relationship with a patient.

SANCTION

The ALJ proposed revoking Dr. Smith's license. The ALJ noted no mitigating factors, under COMAR 10.32.02.09B(5), and noted eight aggravating factors under COMAR 10.32.02.09B(6). These include: Dr. Smith's prior disciplinary history with the Board; the offense was conducted deliberately; the offense had the potential for harm; the offense was part of a pattern of detrimental conduct; the patient was especially vulnerable; Dr. Smith attempted to hide the misconduct from others; Dr. Smith presented false testimony; and Dr. Smith did not cooperate with the investigation. Additionally, Dr. Smith's concealment of his relationship with Patient B led the Board to impose a less stringent sanction when he was disciplined for his sexual relationship with Patient A because the Board believed it was an isolated incident. Had he been honest during his prior Board investigation and had the Board been informed that Dr. Smith's boundary violation was not an isolated event, but was part of a pattern of similar misconduct, it is likely that the Board would have imposed a significantly harsher sanction. The ALJ further noted that Dr. Smith has shown little insight as to the severity of his actions and failed to acknowledge any wrongdoing.

Before the Panel, Dr. Smith argued that the Panel should not revoke his license because the Program determined that he was safe to practice with certain restrictions on his license and that revoking his license would harm the public because there is a shortage of endocrinologists. The State responded by explaining that the Program's recommendation was made without the knowledge that Dr. Smith would subsequently disavow his admissions of wrongdoing.

The Panel finds the ALJ's reasoning and the State's arguments persuasive. Dr. Smith's violations are significant and demonstrate a troubling pattern of conduct. Rather than a single isolated instance of boundary crossing, Dr. Smith has demonstrated a pattern of detrimental

conduct and a complete lack of understanding of the required boundaries between professional and personal relationships.

Dr. Smith knew about the potential vulnerability of Patient B, including her social-emotional history of depression, PTSD, and her prior abusive relationships, before he entered into a sexual relationship with her. Dr. Smith nevertheless entered into a sexual relationship with her while she was a patient.

Dr. Smith explained his prescribing to family members as "common" and in his circumstance "productive" and "successful." The ALJ found that Dr. Smith demonstrated no understanding of why treating family members was a conflict or potentially dangerous. Treating family members in areas that were entirely outside his area of expertise and for chronic conditions poses significant patient safety concerns. Dr. Smith's treatment of his family members reflects an ignorance of or indifference to patient-physician boundaries.

The Program noted that Dr. Smith acknowledged that he participated in boundary violations. Dr. Smith has now disclaimed any violations pertaining to Patient A and his family members and disavowed his statements made to the Program regarding Patient B. The Program's recommendations were based on his admission and apparent understanding of the violations. Dr. Smith's subsequent denials render the Program's recommendation irrelevant.

Dr. Smith's treatment of family members was repeated several times. His sexual relationship with Patient B was followed by his relationship with Patient A. The Panel has little confidence that this type of behavior will not recur because Dr. Smith has demonstrated a pattern of misconduct and has not shown any understanding of appropriate boundaries with either patients or family members. Finally, his dishonesty before the Board in his original interview and his later varying explanations for his misstatements to the Board demonstrate such a

troubling lack of candor that the Board has no trust in Dr. Smith's reassurances. Considering the many aggravating factors in the case, the lack of mitigating circumstances, and Dr. Smith's prior discipline for similar misconduct, the Panel adopts the ALJ's proposed sanction of revocation.

ORDER

Pursuant to Health Occ. § 1-212(c) and § 14-404(a)(3)(ii), (11), and (33), it is, by an affirmative vote of a majority of a quorum of the Disciplinary Panel B, hereby

ORDERED that the license of Stephen R. Smith, M.D. to practice medicine in Maryland, license number **D14957,** is **REVOKED**; 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).

02/08/2022
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. Smith 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. Smith 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 WILLIS GUNTHER BAKER,**
PHYSICIANS	*	**AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE**
STEPHEN R. SMITH, M.D.,	*	**OF ADMINISTRATIVE HEARINGS**
RESPONDENT	*	
LICENSE No.: D14957	*	**OAH No.: MDH-MBP-71-21-02096**

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PROPOSED DECISION

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

STATEMENT OF THE CASE

On November 13, 2020, a disciplinary panel of the Maryland State Board of Physicians (Board) issued charges against Stephen R. Smith, M.D. (Respondent) for alleged 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. 2020) (Act). The Respondent is charged with violating section 14-404 of the Act, specifically Health Occ. § 14-404(a)(3)(ii), unprofessional conduct in the practice of medicine; 14-404(a)(11), willfully making or filing a false report in the practice of medicine; and 14-404(a)(33), failure to cooperate with a lawful investigation conducted by the Board or a disciplinary panel. *Id.* (Supp. 2020); Code of Maryland Regulations (COMAR) 10.32.02.03E(3)(d). Further, the Board determined that these actions

constitute a violation of the Board's regulations promulgated under Md. Code Ann., Health Occ. § 1-212(a)(1) (prohibiting sexual misconduct).

The 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).

I held a remote hearing on June 8, 2021 via the Webex platform from the OAH in Hunt Valley, Maryland. Md. Code Ann., Health Occ. § 14-405(a) (Supp. 2020); COMAR 10.32.02.04; 28.02.01.20B. John T. Sly, Esquire, represented the Respondent, who was present. Robert 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. 2020); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

1. Did the Respondent violate the cited provisions of the applicable law? If so,
2. What sanctions are appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

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

Bd. Ex. 1 - Respondent's Licensing Information, pp. 1-4[1]

Bd. Ex. 2 - Transcribed Interview of the Respondent, January 28, 2019, pp. 5-18

Bd. Ex. 3 - Consent Order, November 8, 2019, pp. 19-36

[1] All references to Board Exhibit page numbers are the Bates stamp numbers in the lower right corner.

Bd. Ex. 4 - August 18, 2020 Email from the Maryland Professional Rehabilitation Program (MPRP) to the Board, attaching the [redacted] Program [redacted] Assessment Report of the Respondent, July 2, 2020, pp. 37-54

Bd. Ex. 5 - Correspondence from the Board to the Respondent, August 20, 2020, pp. 55-56

Bd. Ex. 6 - Email from John Sly to Board attaching Correspondence from the Respondent, August 27, 2020, pp. 57-60

Bd. Ex. 7 - Subpoena and Medical Records for Patient B, received by the State, September 9, 2020, pp. 61-124

Bd. Ex. 8 - Certification of Patient B Medical Records, September 26, 2020, pp. 125-26

Bd. Ex. 9 - Board Report of Investigation, September 28, 2020, pp. 127-30

Bd. Ex. 10 - American Medical Association (AMA) Code of Medical Ethics' Opinion 8.19, pp. 131-32

Bd Ex. 11 - AMA Code of Medical Ethics' Opinion 1.2.1, pp. 133-34

Bd. Ex. 12 - AMA Code of Medical Ethics' Opinion 9.1.1, pp. 135-36

Bd. Ex. 13 - *Curriculum Vitae*, [redacted], M.D., pp. 137-38

Bd. Ex. 14 - Report of Dr. [redacted], March 12, 2021, pp. 139-42

Bd. Ex. 15 - Disciplinary Charges against the Respondent, Case No.: 7720-0045A, pp. 143-50

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

Resp. Ex. 1 - *Curriculum Vitae*, Stephen R. Smith, M.D.

Testimony

The following witness testified on behalf of the Board: [redacted] M.D. who was admitted as an expert in Internal Medicine, Gastroenterology, and Professional Ethics.

The Respondent testified in his own behalf.

PROPOSED FINDINGS OF FACT[2]

The parties agreed to the following stipulations of fact in the captioned case that I find as facts by a preponderance of the evidence:

1. On March 15, 1973, the Board issued the Respondent a license to practice medicine in the State of Maryland under License Number D14957.

2. The Respondent has retained continuous licensure in Maryland since that time. The Respondent's license is scheduled for renewal on or before September 30, 2021.

3. In 2018, the Board initiated an investigation of the Respondent after receiving a series of complaints involving his prescribing practices.

4. During the course of its investigation, the Board conducted a transcribed, under-oath interview of the Respondent on January 28, 2019.

5. After completing its investigation, Disciplinary Panel A ("Panel A") of the Board issued disciplinary charges against the Respondent on July 18, 2019, under Board Case Numbers 2218-0253A and 2219-0014A.

6. The Respondent resolved Panel A's charges by entering into a public Consent Order, dated November 8, 2019, consisting of Findings of Fact, Conclusions of Law and an Order (Consent Order). Panel A found as a matter of law that the Respondent violated the following provisions of the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101 *et seq.*: Health Occ. § 14-404(a)(3) Is guilty of: (ii) Unprofessional conduct in the practice of medicine; Health Occ. § 14-404(a)(22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care, in violation of Health Occ. § 14-404(a)(22); and Health Occ. § 14-404(a)(40) Fails to keep adequate medical records as determined by appropriate peer review. Panel A also found that the

[2] I have replaced all references to the Respondent's name to "the Respondent."

Respondent committed sexual misconduct in violation of Health Occ. § 1-212 and COMAR 10.32.17.01 *et seq.*

7. Panel A imposed sanctions that included the following: a public reprimand; permanently prohibiting the Respondent from prescribing or dispensing all controlled dangerous substances (CDS); and imposing probation for a minimum period of one (1) year, subject to probationary conditions including enrollment in the Maryland Professional Rehabilitation Program (MPRP) and compliance with its directives; and within six (6) months, enroll in and successfully complete Board-approved courses in (1) medical recordkeeping and (2) professional boundaries.

8. The Respondent enrolled in MPRP on November 22, 2019.

9. By email dated December 19, 2019, the Board notified the Respondent that it had approved courses in medical recordkeeping and professional boundaries that are offered at [redacted].

10. By facsimile transmission to the Board dated March 20, 2020, the Respondent submitted certificates from [redacted] that he had completed courses in: medical recordkeeping (course dates, February 20-21, 2020); and medical ethics, boundaries and professionalism (course dates, February 27-28, 2020).

11. As part of his enrollment in MPRP, MPRP referred the Respondent to the [redacted] Program [redacted] for a fitness-for-duty evaluation.

12. [redacted] conducted its evaluation of the Respondent on March 2-4, 2020.

13. [redacted] issued a report of its findings, dated July 2, 2020.

14. MPRP referred the [redacted] report to the Board on August 18, 2020.

15. By letter dated August 20, 2020, the Board requested that the Respondent provide a written response to certain disclosures he made during his [redacted] assessment.

16. By email dated August 27, 2020, the Respondent's legal counsel forwarded a letter dated August 27, 2020 from the Respondent, in which the Respondent provided a response to the allegations raised in the Board's August 20, 2020, letter.

17. On September 9, 2020, the Board issued a *subpoena duces tecum* (SDT) to the Respondent for the medical records of Patient B.[3]

18. On September 10, 2020, the Respondent responded to the SDT and provided the medical records for Patient B.

19. On September 28, 2020, the Board received a form titled, *Certification of Medical Records Form*, from the Respondent, dated September 26, 2020, in which he certified that he provided his complete medical records pertaining to Patient B.

20. On September 28, 2020, Board Compliance Analyst Zachary Spivey issued a Report of Investigation regarding this matter.

21. On November 13, 2020, Panel A issued a document titled, *Charges Under the Maryland Medical Practice Act*, under Case Number 7720-0045A, alleging that the Respondent violated the following: Health Occ. § 14-404(a)(3) Is guilty of: (ii) Unprofessional conduct in the practice of medicine; Health Occ. § 14-404(a)(11) Willfully makes or files a false report or record in the practice of medicine; and (33) Fails to cooperate with a lawful investigation of the Board or a disciplinary panel. Panel A also charged the Respondent with violating the Board's regulations promulgated under Health Occ. § 1-212(a)(1).

[3] The original stipulation referred to "Patient [redacted]." However, throughout the hearing and in other documents this person is referred to as "Patient B." They are the same person and for ease of reference and for confidentiality, they will be referred to as "Patient B" in this decision.

Having considered all of the evidence presented, I find the following additional facts by a preponderance of the evidence:

22. The Consent Order was a result of an investigation of the Respondent pertaining to questionable distribution of CDS to patients and an inappropriate sexual relationship with a female patient, Patient A.

23. During [redacted]'s evaluation of the Respondent, the Respondent revealed that he had provided medical care and prescribed medication to [redacted] and Patient B, [redacted]

24. [redacted] The Respondent provided medical care to [redacted] by prescribing medications for food allergies when they travelled and treating her for upper respiratory infections and hay fever. The Respondent is not an allergist. In 1984, the Respondent took a hospital position in Saudi Arabia. [redacted]

25. [redacted]

26. [redacted] The Respondent provided medical care to [redacted] for diabetes and hypertension [redacted]

27. In January 1998, the Respondent began treating Patient B for hypothyroidism after a referral from Patient B's primary care physician. Patient B had a mental health history of

[4] I will use the first initial to identify [redacted] referred to in order to protect confidentiality.

depression and PTSD, and was in an abusive relationship, all of which she shared with the Respondent. Early on during treatment, the Respondent learned that he and Patient B shared an interest in art and a relationship began outside the office and became sexually intimate for several years while Patient B remained a patient.

28. The Respondent's medical records regarding Patient B end abruptly in June 2005 with an intent that she would return for care. The Respondent did not terminate the medical relationship in writing and did not refer Patient B to another care provider. The Respondent continued to write refill prescriptions for Patient B over the years as they maintained a friendship. The Respondent did not keep records of the continuing care.

29. Patient B's medical file that the Respondent produced during the investigation was not the complete file that the Respondent had maintained as it had been "thinned" in March 2013 because it was too thick.

30. [redacted] When the prescription ran out, the Respondent provided prescription refills t[redacted] related to her [redacted] because it was expensive for her to see the [redacted] The Respondent also prescribed medication for [redacted] when they travelled internationally for such potential conditions as malaria, diarrhea, and motion-sickness and other medications related to specific places of travel. [redacted]

31. Between January 2017 and June 2018, the Respondent saw Patient A fifteen times for various health conditions including chronic pain and anxiety. The Respondent prescribed

Patient A oxycodone and benzodiazepines without acquiring her past medical records. During that timeframe, the Respondent became sexually involved with Patient A, who he would invite back to his office late at night or to his home. Due to prostatectomy, the Respondent was incapable of intercourse.

32. The Respondent did not charge Patient A her for her care visits because he did not take her insurance. Patient A was forty-six years younger that the Respondent. Patient A became pregnant and the Respondent wanted to reduce the dosage of her opioids, which angered her. The relationship between the Respondent and Patient A ended when her fiancée was released from prison.

33. On January 28, 2019, the Respondent falsely answered "No, mmh-mmh" during his interview by the Board in relation to its 2018 investigation regarding Patient A when asked if he ever had any kind of personal relationship with any other patients.

DISCUSSION

Legal Framework

When not otherwise provided by statute or regulation, the standard of proof in a contested case hearing before the OAH is a preponderance of the evidence, and the burden of proof rests on the party making an assertion or a claim. Md. Code Ann., State Gov't § 10-217 (2014); COMAR 28.02.01.21K. To prove an assertion or a claim by a preponderance of the evidence means to show that it is "more likely so than not so" when all the evidence is considered. *Coleman v. Anne Arundel Cty. Police Dep't*, 369 Md. 108, 125 n.16 (2002). In this case, the Department bears the burden to show that the Respondent violated the cited provisions of the applicable law by a preponderance of the evidence. COMAR 28.02.01.21K(1)-(2)(a).

The grounds for reprimand or probation of a licensee, or suspension or revocation of a license under the Act include the following:

> (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 disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> . . .
>
> (3) Is guilty of:
> (i) Immoral conduct in the practice of medicine;
> (ii) Unprofessional conduct in the practice of medicine;
>
> . . .
>
> (11) Willfully makes or files a false report or record in the practice of medicine;
>
> . . .
>
> (33) Fails to cooperate with a lawful investigation conducted by the Board or a disciplinary panel;
>
> . . .

Md. Code Ann., Health Occ. § 14-404(a) (Supp. 2020).

Md. Code Ann., Health Occ. § 1-212 provides:

> (a) Each health occupations board authorized to issue a license or certificate under this article shall adopt regulations that:
>
> (1) Prohibit sexual misconduct; and
>
> (2) Provide for the discipline of a licensee or certificate holder found to be guilty of sexual misconduct.

Pursuant to Health Occupations Article section 1-212, the Board promulgated COMAR 10.32.17.[5] COMAR 10.32.17.02B defines sexual contact between a physician and patient:

> (2) Sexual Impropriety.
>
> (a) "Sexual impropriety" means behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient or key third party regardless of whether the sexual impropriety occurs inside or outside of a professional setting.

[5] The references to COMAR 10.32.17 are the regulations in effect from 2000 to 2019. The regulations were revised in 2019, which was subsequent to the actions alleged in this case: Effective date: March 6, 2000 (27:4 Md. R. 454) and amended effective May 20, 2019 (46:10 Md. R. 488).

(b) "Sexual impropriety" includes, but is not limited to:

. . .

(iii) Using the health care practitioner-patient relationship to initiate or solicit a dating, romantic, or sexual relationship.

(3) "Sexual misconduct" means a health care practitioner's behavior toward a patient, former patient, or key third party, which includes:

(a) Sexual impropriety;

(b) Sexual violence, or

(c) Engaging in a dating, romantic, or sexual relationship which violates the code of ethics of the American Medical Association...or other standard recognized professional code of ethics of the health care practitioner's discipline or specialty.

(4) Sexual Violation

(a) "Sexual violation" means health care practitioner-patient . . . sex whether or not initiated by the patient . . . and engaging in any conduct with a patient . . . that is sexual or may be reasonably interpreted as sexual, regardless of whether the sexual violation occurs inside or outside a professional setting.

COMAR 10.32.17.03 states that physicians may not engage in sexual misconduct and that a violation of Health Occupations Article section 14-404(a)(3)(unprofessional conduct) includes sexual misconduct.

The Respondent is charged with unprofessional conduct in the practice of medicine. Therefore, a chronological review of decisions pertaining to "conduct in the practice of medicine" is instructive. In *McDonnell v. Comm'n on Med. Discipline*, 301 Md. 426 (1984), the court concluded that the legislature did not intend for a physician's general moral character to be subject to sanction, thus, "in the practice of medicine" "is directly tied to the physician's conduct in the actual performance of the practice of medicine, *i.e.*, in the diagnosis, care, or treatment of patients." *Id.* at 436-437 (attempt by physician to intimidate witnesses scheduled to testify against him at a medical malpractice trial). However, in *Board of Physician Quality Assurance*

v. Banks, 354 Md. 59 (1999), the court rejected Banks' argument that his sexual harassment of co-workers during the hours of employment was not immoral or unprofessional conduct in the practice of medicine. The *Banks* Court found the physician's behavior "sufficiently intertwined with patient care to constitute misconduct in the practice of medicine." *Id.* at 76-77.

In *Finucan v. Maryland Board of Physician Quality Assurance*, 380 Md. 577 (2004), the court affirmed the Board's action against Finucan for having "used the physician-patient relationship for purposes of facilitating the engagement of current patients in sexual activities." And in *Cornfeld v. State Board of Physicians*, 174 Md. App. 456 (2007), a physician was found to have committed unprofessional conduct in the practice of medicine when he made false statements to the hospital and Board regarding his conduct during a surgical procedure. Finally, in *Kim v. Maryland State Board of Physicians*, 423 Md. 523 (2011), the court found that false information by a physician on his renewal application constituted unprofessional conduct in the practice of medicine. *Id.* at 547-548.

It is under this framework that the Respondent's alleged actions are reviewed.

Dr. [redacted]'s Testimony

In addition to the documents, statutes, and regulations already cited, the Board presented the testimony of [redacted] M.D. who was admitted as an expert in Internal Medicine, Gastroenterology, and Professional Ethics. Dr. [redacted] was initially board certified to practice in 1989 but stopped seeing patients in 2014. Dr. [redacted] is currently employed by the Board as its Physician Consultant, the only physician employed by the Board, and has been in this role since April 2015. She served as a member of the Board from 1999 to 2003. Her *Curriculum Vitae* is Board Exhibit 13.

Dr. [redacted] testified that she was asked to review the Respondent's case for the Board following the report from [redacted]. Dr. [redacted] has never met the Respondent but reviewed his history with the Board, the [redacted] Fitness for Duty evaluation, and the exhibits submitted by the Board. Dr. [redacted] reviewed an incident from 2015 when the Respondent was being investigated by the Board after a complaint by a veterinarian that the Respondent had issued a fraudulent prescription for a cat by using the name of [redacted]. The Respondent received an advisory letter. Dr. [redacted] testified that, in 2016, the Respondent received another advisory letter for prescribing CDS to an active addict without monitoring him through urine analysis and toxicology screening.

Dr. [redacted] also reviewed the 2018 complaints that led to the 2019 Consent Decree. She became involved with the subsequent investigation that arose from the Respondent's interview at [redacted] where he revealed that he provided medical treatment to [redacted] and had a sexual relationship with Patient B. Dr. [redacted] described why these physician-patient relationships demonstrated serious boundary violations because they involved trust, knowledge, emotion, and influence and resulted in sexual misconduct under COMAR 10.32.17.03, particularly as to Patient A and Patient B.

Dr. [redacted] noted that the Respondent showed ignorance and a lack of understanding of his fiduciary role in the doctor-patient relationship in that he believed that the doctor-patient relationship and the sexual relationship with a patient were two completely separate things. The Respondent expressed during his Board interview in January 2019 that he had a "friendly personal relationship" with Patient A and when pressed further about the sexual nature of the relationship the Respondent stated he did not think it was appropriate for the Board to "pry into

personal matters." (Bd. Ex. 2, at p. 13, Transcript, p. 42.)[6] Dr. [redacted] testified that this perception that the Respondent "can take off his white coat, exit the office, and then have sex with a patient and [the] two are totally unrelated…is incongruous and concerning." (Transcript, p. 43.) Dr. [redacted] expressed concerns that the Respondent's responses in the Board interview demonstrated that he did not consider the potential negative impact of a sexual relationship on the patient and the power dynamic that the physician exercises over a patient. This was further developed in the [redacted] Report that was reviewed by Dr. [redacted]. Dr. [redacted] testified that the Respondent's assessments indicated that he liked to be assertive and in control and presented as "dominant, forceful, and socially ascendent," with "narcissistic personality traits." (Transcript, p. 52; Bd. Ex. 4, pp. 48, 51.)

Dr. [redacted] noted that the Respondent had just completed a boundaries and ethics course at [redacted] prior to going to [redacted] and in the self-response boundary assessment, the Respondent scored "0" which meant that he had answered all twenty-five questions related to actions considered potential boundary violations as "never." (Transcript, pp. 52-53.) Dr. [redacted] testified that because the Respondent had already acknowledged the sexual relationship with Patient A prior to this assessment, it demonstrated that he "disassociates from [his] fiduciary role as a physician." (Transcript, p. 54.) She testified that the Respondent did not put his patients' well-being first, but fulfilled his own self-interest by pursuing sexual relationships with Patient A and B.

In reviewing Patient B's medical records provided by the Respondent (Bd. Ex. 7), Dr. [redacted] found it significant that Patient B presented with a history of depression in January 1998 and that her depression, PTSD, and spousal abuse were noted in the record. She noted that there was only one report early on to Patient B's primary care physician despite Patient B seeing the

[6] References to "Transcript" are for the transcript created from this June 8, 2021 hearing.

Respondent until at least June 2005 and the records abruptly end with no discharge letter and with the plan that the patient will return for future care. Dr. [redacted] noted this was a clear indication that the doctor-patient relationship was not terminated. (Transcript, pp. 55-60.) Dr. [redacted] testified that the patient record, the [redacted] report, and the Respondent's letter to the Board (Bd. Ex. 7) demonstrate that the Respondent had an ongoing sexual relationship with Patient B that began in the doctor-patient context when the parties discussed art during medical visits, which led to a relationship outside the office that developed into a sexual relationship while Patient B remained an active patient. Dr. [redacted] sated that in her expert opinion, the Respondent "engaged in sexual misconduct with Patient B and that represents unprofessional conduct in the practice of medicine." (Transcript, p. 60.)

Dr. [redacted] discussed how the Respondent's actions were a clear violation of the American Medical Association (AMA) Code of Medical Ethics and related Opinions. Dr. [redacted] reviewed the three AMA Ethical Opinions submitted by the Board: Opinion 8.19 – Self-Treatment or Treatment of Immediate Family Members (Bd. Ex. 10); Opinion 1.2.1 – Related to Boundaries - Self-Treatment or Treatment of Immediate Family Members (Bd. Ex. 11); Opinion 9.1.1 – Romantic or Sexual Relationships with Patients (Bd. Ex. 12).

Opinion 9.1.1 (Bd. Ex. 12) states:

> Romantic or sexual interactions between physicians and patients that concurrently occur with the patient physician relationship are unethical. Such interactions detract from the goals of the patient-physician relationship and may exploit the vulnerability of the patient, compromise the physician's ability to make objective judgements about the patient's health care, and ultimately be detrimental to the patient's well-being.
>
> A physician must terminate the patient-physician relationship before initiating a dating, romantic, or sexual relationship with a patient.
>
> Likewise, sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship.

> Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previously professional relationship, or if a romantic relationship would otherwise foreseeably harm the individual.
>
> In keeping with a physician's ethical obligations to avoid inappropriate behavior, a physician who has reason to believe that nonsexual, nonclinical contact with a patient may be perceived as or may lead to romantic or sexual contact should avoid such contact.

Dr. [redacted] applied this ethical opinion to the Respondent's case and testified that it was clear that Patient B was in a trusting relationship with the Respondent because she saw him for at least eighteen patient visits. She noted that the Respondent had specific knowledge of details regarding Patient B's mental health and personal issues which made her vulnerable. The Respondent stated in his letter to the Board (Bd. Ex. 6) that he ant Patient B became friends first then developed a sexual relationship, indicating an emotional attachment. Dr. [redacted] opined that the Respondent wielded influence over Patient B due to the power differential which he could exploit. (Transcript, p. 65.) Dr. [redacted] noted that even if Patient B was a willing participant or even initiated the sexual relationship, it would still constitute an ethical violation by the Respondent. (Transcript, p. 67.) She further noted that even if Patient B was no longer being treated by the Respondent at the time they began a sexual relationship, it was still an ethical violation. (Transcript, pp. 75-76, 79.) Dr. [redacted] testified that due to her mental health history and her abusive spouse, Patient B was vulnerable to manipulation by the Respondent and less likely to report the abuse by the Respondent for fear of her husband. (Transcript, p. 109.) Dr. [redacted] opined that harm to Patient B was foreseeable due to the vulnerability of her mental state and the volatility of her marriage, causing breach of trust and damage to Patient B's self-confidence that could prevent her from seeking further medical care from another doctor. (Transcript, pp. 112-13.)

On cross-examination Dr. [redacted] was asked about AMA Opinion 8.19. Opinion 8.19 states that physicians generally should not treat members of their immediate family because "professional objectivity" and "medical judgment" can be compromised by the physician's personal feelings. It may be uncomfortable for the physician "to probe sensitive areas when taking the history" or perform a full intimate examination, and the patient may not disclose "sensitive information" or want to undergo "intimate examination" because of the familial relationship. Physicians "may be inclined to treat problems that are beyond their expertise or training." Tensions could arise in the professional and personal relationship if there is a "negative medical outcome." "Concerns regarding patient autonomy and informed consent" may result in the patient not seeking a second opinion or going forward with a procedure so as not to offend the family member. Similarly, the physician "may feel obligated to provide care to a family member..." There are exceptions for an "emergency" or "isolated settings" where no other qualified physician is available, or some "situations in which routine care is acceptable for short-term, minor problems." (Bd. Ex. 10.)

Dr. [redacted] indicated that there is no absolute prohibition of a physician providing care to a family member, but that it is restricted to emergencies and short-term situations. She also noted that she was not provided the [redacted] medical records, nor the Respondent's prescription records, if any records existed, so she was not fully aware of the extent of the care provided and could not render an expert opinion regarding a violation of AMA Opinion 8.19.

However, Dr. [redacted] was called in rebuttal and based on the Respondent's own testimony regarding the care and treatment he provided for [redacted], particularly [redacted], Dr. [redacted] opined that this constituted a boundary violation and was unprofessional conduct [redacted]

[redacted] the care was not brief or of an emergency nature, and because it is a loved one, the physician could lack objectivity and the patient could withhold sensitive information. (Transcript, p. 196.)

Dr. [redacted] also considered the treatment of [redacted] to be an unprofessional conduct boundary violation. [redacted] The Respondent was prescribing medication outside his field, as he was not a [redacted]. Dr. [redacted] testified that the [redacted] would track medication and monitor the patient with other tests and there was no evidence to demonstrate that the Respondent provided the necessary care outside of prescribing medication (*Id.*)

Dr. [redacted] also stated that the Respondent does not have insight into his boundary violations and that treating Patient B's husband while he was in a sexual relationship with Patient B was "an extraordinary boundary violation." (Transcript, p. 197.)[7]

Respondent's Testimony

The Respondent testified in his own behalf. He described his medical training and his specialties in endocrinology and internal medicine. The Respondent indicated that his current patient population comes from "all parts of society, medical assistance to the well-heeled." (Transcript, p. 121.)[8]

The Respondent agreed that he provided medical care to [redacted] describing the care he provided for each. The Respondent provided medical care to [redacted] by prescribing medications for a serious food allergy related to mustard that [redacted]

[7] This issue was not among the charges as the Board was not aware of this patient until the Respondent mentioned it at the hearing. (Transcript, p. 187-90.)
[8] The Transcript show the end of this statement as "inaudible," my notes reflect the Respondent's quote.

manifested while they were travelling in Turkey, and the Respondent prepared medications to treat [redacted] for food allergies on about six foreign vacations. [redacted] did not see an allergist and relied on the Respondent for her allergy medications. The Respondent treated [redacted] for upper respiratory infections and hay fever, as well. (Transcript, pp. 122, 145-147.)

The Respondent testified that he provided medical treatment to [redacted] for diabetes and hypertension, [redacted], and that he continues to treat [redacted] currently by providing prescriptions. (Transcript, pp. 122, 149).[9]

[redacted] The Respondent testified that at one point, [redacted] ran out of [redacted] medication and could not afford to see [redacted], so the Respondent renewed her [redacted] medication and continued to do that when her prescription ran out. The Respondent also prescribed medications when they travelled to the Amazon and Galapagos for prevention of malaria, diarrhea, and motion sickness (Transcript, pp. 151-52.) The Respondent also admitted to writing a prescription in [redacted]'s name for her cat because the vet prescription was much more expensive for the same medicine. (Transcript, p. 153.)

The Respondent testified that he voluntarily submitted to an interview before the Board in January 2019 related to the Board's investigation of the 2018 complaints and responded to questioning regarding Patient A. The Respondent stated that he and the Board entered a Consent Decree and the Respondent agreed to no longer prescribe CDS and also agreed to attend courses on medical record keeping and professional boundaries, which he completed. The Respondent testified that he has been participating in the MPRP since November 2019. The Respondent

[9] The Respondent was inconsistent in his testimony regarding when she developed hypertension and diabetes and when he began treating her, [redacted]

described the 3-day program that he attended at [redacted] and the evaluators who assessed him. He stated that they asked many questions about Patient B that he "was not expecting to discuss" at the time, so his answers were "off the cuff" without having the benefit of his patient records. (Transcript, p. 128.)

The Respondent testified that Patient B first became his patient in 1998 and remained a patient until June 2005, when her medical condition resolved. "Following that, by mutual agreement, we transferred from a previous doctor-patient relationship to a personal relationship, which [was] initiated in mutual interest in art that was the catalyst, that made us interested in each other..." (Transcript, p. 130.) The Respondent claimed that he never saw Patient B again as a patient after the medical records ended in June 2005. The Respondent testified that he and Patient B began to "socialize" within "a month, or two or three" after June 2005. (Transcript, p. 132.)

The Respondent explained that Patient B came to see him as a referral from her primary care physician for treatment of hypothyroidism. He denied prescribing medications or treating Patient B for depression, although he did suggest to her that it could be related to her ongoing complaints. The Respondent did send an initial report in 1998 to Patient B's primary care physician, but was unable to confirm if other reports were sent. The Respondent testified that on the last visit in June 2005, Patient B expressed that she had no complaints and was completely satisfied with her treatment. (Transcript, p. 136.) When asked if he exploited Patient B with the knowledge he had based on his treatment, the Respondent denied it. The Respondent denied that he needed to send Patient B a formal discharge letter because he was seeing her as a consultant not a primary physician.

On cross-examination, the Respondent was asked whether in his thirty or forty years as a medical professor or chairing a department he ever had a situation where a physician under his supervision had an inappropriate relationship with a patient, to which he replied, "Not that I can recall." (Transcript, p. 143.) When asked if he was aware that the Board had instituted regulations regarding sexual misconduct in 2000, the Respondent replied, "I'm aware of that now," but also indicated he did not recall ever seeing the information until this case arose. (Transcript, p. 144.)

The Respondent was asked about Patient A who he began seeing as a patient in 2017. He admitted to prescribing an opioid for chronic pain and benzodiazepines for post-traumatic arthritis. The Respondent testified that the sexual relationship began after Patient A came to him seeking help because her fiancé was jailed, she was alone, and she did not know how to handle her responsibilities. They had dinner together and Patient A expressed that she was looking for affection, which the Respondent obliged. The Respondent stated that, "I did not allow our relationship as developing friends to cloud or interfere [with] the medical relationship." (Transcript, p. 155.) When asked specifically if the Respondent believed he could have a sexual relationship with a patient as long as it did not interfere with the professional relationship the Respondent stated, " [w]ell that was certainly my intention, to keep the two separate and I think I did. But I understand that in spite of that, the regulations are very negative in this respect." (Transcript, p. 157.)

The Respondent also revealed during cross-examination that he saw Patient B's husband as a patient for a diabetes consultation during the same time frame that he and Patient B were sexually involved. (Transcript, p. 188.) Patient B brought her husband to see the Respondent, and when questioned about this, he stated, "[i]t was not unprofessional." (*Id.*)

The Respondent admitted to boundary violations in his [redacted] assessment. When questioned at the hearing he stated that he admitted boundary violations as to Patient A, and did not know about [redacted] or Patient B, stating "I don't know what the final opinion is on family care. I understand that it is common. I think it is productive, successful in my case. I don't think there is anything wrong with it." (Transcript, p. 190.)

Analysis

This is a rather unique scenario as the parties basically agree on the facts. The Respondent did not deny that he provided medical treatment to [redacted] and that he had sexual relationships with two patients, Patient A and Patient B. In fact, these patient relationships were revealed by the Respondent himself during his three-day analysis session a[redacted].

The issue that the Respondent did contest most fervently was the timing of his relationship with Patient B. The Board contends that Patient B was an active patient of the Respondent when the sexual relationship began, the Respondent claimed the doctor-patient relationship terminated before the sexual relationship began.

The Respondent sought to have Dr. [redacted]'s expert testimony discounted because she is an employee of the Board and it was upon her advice that the Board charged the Respondent. However, I find that Dr. [redacted]'s position makes her uniquely qualified, particularly in medical ethics, to provide expert opinion testimony regarding violations since this is her a large part of her daily profession. Her analysis and testimony were well-supported by the record. Expert witnesses regularly testify before the OAH on behalf of the agency where they are employed. Therefore, I find that Dr. [redacted]'s testimony was worthy of consideration and weight.

Patient B

The Board relied on statements made by the Respondent to the [redacted] and in a letter to the Board as they related to Patient B. During his [redacted] examination, the Respondent indicated that "[Patient B] was a patient of [the Respondent] in 2000. Their relationship turned into a sexual relationship in 2005 and continued until 2007 while she was still a patient of his." (Bd. Ex. 4, p. 50.) Upon receipt of the [redacted] report, the Board requested that the Respondent provide a written response regarding his admission of having a sexual relationship with Patient B and requested an explanation as to why he had not disclosed this relationship during his January 2019 Board interview.[10] (Bd. Ex. 5, p 50.)

The Respondent's excuse for not disclosing the Patient B relationship to the Board Interviewer was that he understood the question to apply only to "contemporaneous events and relationships." (Bd. Ex. 6, p. 58.) The Respondent continued:

> "With regard to [Patient B], she first appeared as a patient with hypothyroidism in my office, in about 2000. Shortly thereafter it became apparent that she and I shared a broad interest in art, and a platonic friendship evolved on that basis. Five years later, we also had an occasional intimate relationship that extended over about two years, ending without emotional drama. I continued to see her occasionally as a patient thereafter, and even now, when she is no longer a patient, we continue to remain on cordial terms. As I described, my best interpretation of my answer to the Board's investigators was that I was in the mindset of the contemporary period. My relationship with [Patient B] was 13-15 years ago.

(Bd. Ex. 6, p. 59.)

At the hearing the Respondent testified that Patient B stopped being his patient on June 23, 2005 and that there was a "line in the sand, there in 2005, the last visit, and then following that I'm not exactly sure how long, a month or two or three, we began to socialize." (Transcript,

[10] The Interviewer asked, "Did you ever have any kind of personal relationship with any other patients you were treating?" The Respondent replied, "No."

p. 132.) The Respondent later testified that on that last visit, Patient B had achieved a good result, "had no complaints and felt completely satisfied with the result of her treatment." (Transcript, p. 136.)

I do not find the Respondent's testimony credible. His two prior statements indicate that a relationship outside the office began to develop almost immediately between the Respondent and Patient B over their mutual interest in art. The Respondent's own statements support that a sexual relationship with Patient B occurred while she was a patient. He claimed that it was not until he went through Patient B's medical records that he was able to see when the doctor-patient relationship stopped and the romantic relationship began. This statement appears to be inconsistent with the facts and self-serving. It is also not supported by Patient B's June 23, 2005 medical record which shows no indication that she had reached "completely satisfactory results" and ended treatment. In fact, the Respondent sent Patient B for lab work and advised her to return in four months. (Bd. Ex. 7, p. 109.)

Furthermore, even if I were to accept that June 23, 2005 was the last time the Respondent saw Patient B in his office, the Respondent admitted that he continued to provide her with treatment through prescriptions for years during and after their sexual relationship and failed to document it in her medical records. The Respondent also admitted that Patient B's file had been "thinned" and no longer contained "every piece of paper." (Transcript, p. 161-62.) In addition, the Respondent admitted to having a romantic relationship with Patient B within three months of her June 2005 appointment, hardly a vast separation of time. Further, Patient B's records do not demonstrate that the physician-patient relationship was terminated.

Code of Medical Ethics Opinion 9.1.1 discusses the concerns of a relationship with a former patient:

> A physician must terminate the patient-physician relationship before initiating a dating, romantic, or sexual relationship with a patient.
>
> Likewise, sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previously professional relationship, or if a romantic relationship would otherwise foreseeably harm the individual.

(Bd. Ex. 12.)

Dr. [redacted] testified that based on Patient B's history of depression, PTSD, and spousal abuse, all of which were known to the Respondent, coupled with the cultivation of a relationship surrounding a mutual interest in art beginning early in the doctor-patient relationship, the Respondent exploited the trust, knowledge, and emotions of Patient B that all developed from the doctor-patient relationship. Dr. [redacted] also opined that harm was foreseeable because of Patient B's mental health concerns and volatile home situation.

Dr. [redacted] noted that Patient B's records provide no indication that in June 2005 Patient B was cured (as suggested by the Respondent), or that the physician-patient relationship terminated. The Respondent did not provide a termination letter, did not refer Patient B to another provider, did not send a final letter to her primary care physician, and admitted to continuing to treat her with prescriptions after that time.

Even if I were to accept that Patient B became a "former patient" in June 2005, the initiation of a sexual relationship within three months of that time, after treating Patient B for seven years, should have been recognized by the Respondent as inappropriate and foreseeably harmful to Patient B based on her social-emotional history.

I find that the Respondent perpetrated unprofessional conduct in the practice of medicine for sexual impropriety and misconduct as to Patient B in violation of Health Occupations Article section 14-404(a)(3)(ii); COMAR 10.32.17.02B; COMAR 10.32.17.03; *See also, Finucan v. Maryland Bd. of Physician Quality Assurance*, 380 Md. 577 (2004).[11]

Treatment of Family

The Respondent made clear that he found no problem with treating [redacted] since that is "common" practice. He even went so far as to say, "I'm not aware of the opinion on family care. I understand that it is common. I think it is productive, successful in my case. I don't think there's anything wrong with it." (Transcript, p. 190.) While the Respondent testified that he would avoid it in the future, his testimony lacks any understanding as to why it was concerning or how he may have compromised the care of his loved ones.

Opinion 1.2.1 discusses the conflicts related to a physician treating themselves or a family member. While generally reiterating the concern stated in Opinion 8.19, it sets forth the limited circumstances where a physician may treat a family member but also requires that the physician document the treatment and provide relevant information to the patient's primary care physician:

> 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:

[11] While the Respondent's actions do not rise to the extreme level of those demonstrated by Dr. Finucan, the violation is nonetheless the same.

(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.

(Bd. Ex. 11.)

While the Respondent's treatment of [redacted] was within his field, the treatment of [redacted] were not. The Respondent described that [redacted] had a severe allergic reaction when they were traveling in Turkey which he attributed to mustard. Rather than have her assessed by an allergist, the Respondent took it upon himself to treat [redacted]'s severe food allergies whenever they travelled. Similarly, the Respondent took it upon himself to take over the care of [redacted], despite not being a [redacted]. The Respondent testified that he refilled medication that had previously been prescribed by [redacted], rather than pay for her to see her treating physician.[12] [redacted]

Dr. [redacted] noted that the Respondent treated family members' conditions outside his field and may not have provided the proper testing and follow-up required. The seriousness of [redacted]'s condition was particularly disturbing. And while the Respondent treated [redacted] for chronic conditions within his expertise, [redacted] seriously

[12] The Respondent testified that he prescribed [redacted]'s medications when they ran out because she could not afford to see her [redacted].

compromised the physician-patient relationship, the independence o[redacted] in making advised health decisions, and the Respondent's objectivity.

Clearly the Respondent did not take into consideration AMA Opinion 8.19 or 1.2.1 (Bd. Exs. 10 and 11) regarding treatment of family members, as he freely acknowledged that he was unaware of the existence of these ethical opinions until the charges were filed. He testified that he continues to see nothing wrong with treating family members and his demeanor throughout the hearing demonstrated a lack of concern or understanding why his actions posed possible harm or conflicts. In fact, the Respondent testified that in his boundary course at [redacted], the presenter shared that even he was guilty of boundary violations, and the Respondent's takeaway was that they were common and unavoidable. Despite that acknowledgement, the Respondent stated that he would not have any more boundary violations in the future. This statement rang hollow based on the Respondent's own testimony throughout the hearing which lacked understanding of his wrongdoing or insight into how it impacted his family members' care.

I find that the Respondent violated the law regarding unprofessional conduct in the practice of medicine for providing care and treatment to [redacted] in violation of Health Occupations Article section 14-404(a)(3)(ii); *See also,* AMA Opinions 8.19 and 1.2.1 (Bd. Exs. 10 and 11).

False Report and Failure to Cooperate

Pursuant to Health Occupations Article section 14-404, a physician may be disciplined for:

> (a)(11) Willfully mak[ing] or fil[ing] a false report or record in the practice of medicine;
>
> . . .

(33) Fail[ing] to cooperate with a lawful investigation conducted by the Board or a disciplinary panel;

. . .

Md. Code Ann., Health Occ. § 14-404(a) (Supp. 2020).

In bringing this charge, the Board relied on the Respondent's testimony given under oath in his interview by the Board related to the 2018 charge regarding Patient A. During that interview, the Respondent was asked "Did you ever have any kind of personal relationship with any other patients you were treating?" The Respondent replied, "No, mmh-mmh." (Bd. Ex. 2, p. 16.) It is the Board's position that this was untruthful and meant to deceive as the Respondent clearly provided care to [redacted] and Patient B, and the Respondent had a personal and sexual relationship with all four.

The Respondent's position was that he did not understand the question to mean "at any time" but thought it was contemporaneous with the interview.

It is clear based on the [redacted] interview, that the Respondent's answer to this question was untrue. The Respondent's explanation that he misunderstood the question is not credible. It is clear throughout the interview that the Respondent has contempt for the process and does not think the Board should be prying into his personal relationships, despite the fact that the inquiry involved sexual impropriety with Patient A. It was a serious situation relating to the Respondent's future ability to practice medicine and the Respondent was required to be forthcoming. The Respondent failed. The interview was provided as part of a lawful investigation related to the Respondent's practice of medicine.

In *Cornfeld v. State Board of Physicians*, 174 Md. App. 456 (2007), and *Kim v. Maryland State Board of Physicians*, 423 Md. 523 (2011), the court found unprofessional conduct in the practice of medicine where a physician supplied false information to the Board related to their actions as a physician. And while the false information in this case is the result of a singular

statement by the Respondent, the Board is correct that the response weighed heavily on its determination related to the 2018 charges.

I find that the Respondent willfully provided false information and interfered with the lawful investigation of the Board by providing an untruthful answer to a crucial question while under oath in violation of Health Occupations Article sections 14-404(a)(11) and (33).

Sanctions

In this case, the Board has stated that it seeks to impose the disciplinary sanction of revocation. Md. Code Ann., Health Occ. § 14-404(a) (Supp. 2020); COMAR 10.32.02.09A, B(6); COMAR 10.32.02.10. Mitigating and aggravating factors may be included in the sanction determination. COMAR 10.32.02.09B(1). The Respondent offered no mitigating factors into evidence. COMAR 10.32.02.09 B(6) sets forth aggravating factors that may include, but are not limited to:

> (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;
>
> . . .
>
> (g) The patient was especially vulnerable;
>
> (h) The offender attempted to hide the error or misconduct from patients or others;
>
> (j) The offender concealed, falsified or destroyed evidence, or presented false testimony or evidence;
>
> (j) The offender did not cooperate with the investigation; ...

As previously noted, the concealment by the Respondent of his providing care while in relationships with Patient B [redacted] led the Board to impose a less stringent sanction in a prior discipline, believing it was an isolated incident. Had the Respondent cooperated fully with the prior investigation, the Board would have learned that the

Respondent's personal relationships with patients was a pattern that foreseeably could cause harm to his patients due to their vulnerability and the trust they placed in the Respondent. Furthermore, the Board would have had knowledge that the Respondent provided care to his family members outside the area of his expertise, which could have been deemed reckless or negligent.

The Respondent has shown little insight into the severity of his actions. He stated that he provided "successful" care to his family members and saw nothing "wrong with it," even after taking the boundary course. He justified the sexual relationship with Patient B stating he "drew a line in the sand" between the patient and personal relationship, at the same time testifying he was unaware of the regulation prohibiting such a relationship.

The Respondent argued that revocation was too harsh a sanction for things that occurred so many years ago and that [redacted] recommended particular oversight that would allow the Respondent to be fit for continued practice including: ongoing MPRP oversight and support; psychotherapeutic therapy regarding boundaries and personal psychotherapy; chaperones with all female patients in his office; disclosure of his boundary difficulties to his office staff; and annual polygraph examinations, among others. Respondent also argued that there is no absolute prohibition to treating family members and no evidence that the Respondent provided care below the standard of care.

The Board countered that the Respondent demonstrated a "plethora of boundary violations" and used information derived from his professional relationship to develop sexual relationships with two patients. The Respondent should have foreseen the potential harm to both these patients as well as to his family members. The Respondent's role in these relationships was to provide care to his patients, not to provide pleasure for himself.

The Respondent failed to ever acknowledge wrongdoing or understanding that what he did was unethical. He believed he could compartmentalize his personal from his professional. He admitted that he did not keep up with the updates to regulations. And although his misbehavior may have begun many years ago and gone unnoticed, most of the improprieties continued throughout the last twenty years while COMAR 10.32.17, prohibiting sexual misconduct with patients, was in existence.

The Board has provided substantial justification for its recommendation and the appropriate sanction is revocation of licensure. Md. Code Ann., Health Occ. §. 14-404(a) (Supp. 2020); COMAR 10.32.02.09A, B(6); COMAR 10.32.02.10.

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude as a matter of law that the Respondent violated the alleged provisions of the law. Md. Code Ann., Health Occ. § 1-212; Md. Code Ann., Health Occ. § 14-404(a)(3)(ii), (11), and (13) (2014 and Supp. 2020); COMAR 10.32.17.03. As a result, I conclude that the Respondent is subject to disciplinary sanction of revocation for the cited violations. *Id.*; COMAR 10.32.02.09A, B(6).

PROPOSED DISPOSITION

I **PROPOSE** that charges filed by the Maryland State Board of Physicians against the Respondent on November 13, 2020 be **UPHELD**; and

I **PROPOSE** that the Respondent be sanctioned with revocation of his medical licensure.

Signature on File

August 30, 2021
Date Decision Issued

Willis Gunther Baker
Administrative Law Judge

WGB/cj
#193467

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.

Copies Mailed To:

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

Robert Gilbert, Assistant Attorney General
Administrative Prosecutor
Office of the Attorney General
300 West Preston Street, Suite 207
Baltimore, MD 21201

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

John T. Sly, Esquire
Waranch & Brown
1301 York Road, Suite 300
Lutherville, MD 21093

Stephen R. Smith, M.D.
[redacted]

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