IN THE MATTER OF	*	**BEFORE THE**
KWANG B. LEE, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D21580	*	**Case Number: 2017-0285B**

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

CONSENT ORDER

On April 30, 2018, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board"), charged **Kwang B. Lee** (the "Respondent"), License Number D21580, under the Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2014 Repl. Vol. and 2017 Supp.).

The pertinent provisions of the Act under Health Occ. § 14-404(a) provide as follows:

> **§ 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> (a) *In general.* Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel of the Board, 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:
>
> ...
>
> (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; and
>
> ...
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

On June 27, 2018, Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

I. FINDINGS OF FACT

Panel B finds:

1. At all times relevant hereto, the Respondent was licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on February 16, 1978. His license is active and is scheduled to expire on September 30, 2018.
2. The Respondent specializes in anesthesiology. The Respondent represented that he retired from pain management practice in a group setting as of April 2017 and currently practices as an anesthesiologist at a hospital on a part-time basis.
3. On or about October 28, 2016, the Board received a complaint from a patient's family member ("Complainant") stating that the Respondent "blindly" prescribed narcotics to the Complainant's mother without performing appropriate assessments. The Complainant stated that as a result of the Respondent's actions, the Complainant's mother is dependent on the medications.
4. The Board thereafter initiated an investigation of the Respondent's prescribing practices which included referring the matter to peer review. The findings of the peer reviewers are summarized below.
5. The peer reviewers concurred that the Respondent violated the standard of quality

medical care in ten of ten patient records they reviewed and failed to maintain adequate medical records in six of the ten patients they reviewed (identified in the peer review reports as Patients 4, 5, 7, 8, 9, and 10).

6. Specifically, the peer reviewers found that the Respondent failed to meet the standard of quality care and failed to maintain adequate medical documentation for reasons including, but not limited to, the items listed below. The Respondent:

a. Failed to conduct appropriate physical examination and patient history at initial visit and/or follow-up visits, including use of appropriate tests to better understand source of patients' pain – Patients 1, 5, 6, 7, 8, 9. and 10;

b. Failed to consider conservative methods, including adjuvant therapy and a multimodal approach to reduce opiate requirements, including a failure to include a pain rehabilitation program, behavioral therapy, or referral to appropriate providers – Patients 1, 2 3, 4, 5, 6, 8, and 9;

c. Failed to conduct a risk assessment prior to prescribing opioids – Patients 1, 4, 5 6, 7, 9 and 10;

d. Failed to verify dose and frequency of prior medications prescribed to patients – Patients 3, 7, and 8;

e. Failed to document urine screens as part of routine treatment and monitoring, including to patients prescribed a high dosage of opioids who are at a high risk of diversion or abuse – Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10;

f. Failed to conduct continuing assessment of whether opioid prescriptions helped current pain level, and presence of any adverse effects from

prescription – Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10; and

g. Failed to maintain adequate documentation. The Respondent maintained limited documentation, including lack of documentation of dosage and frequency of the medications prescribed by the Respondent, and lack of documentation regarding thought process behind prescribing of opioids– Patients 4, 5, 7, 8, 9 and 10.

7. The peer review, and the issues identified by the peer reviewers with regards to the Respondent's practice, were regarding his pain management practice in a group setting, and not conduct related to his practice as an anesthesiologist in a hospital setting.

8. The Respondent's conduct, in whole or in part, constitutes failure to meet standards of quality care, in violation of Health Occ. § 14-404(a)(22), and failure to maintain adequate medical records, in violation of Health Occ. § 14-404(a)(40).

II. CONCLUSIONS OF LAW

Based on the Findings of Fact, Panel B concludes as a matter of law that the Respondent's conduct constitutes violations of Health Occ. § 14-404(a)(22) and (40).

III. ORDER

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

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

ORDERED that the Respondent is permanently prohibited from prescribing controlled dangerous substances ("CDS"), as CDS are defined and listed under § 5-101 and

§§ 5-401—5-406 of the Criminal Law Article, Md. Code Ann., except the Respondent may prescribe CDS for the administration of anesthesia during surgical procedures at a hospital or ambulatory surgical center; 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 the Respondent is prohibited from supervising allied health professionals, except he may do so in his practice of anesthesiology at a hospital or ambulatory surgical center; and it is further

ORDERED that the Panel may issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program ("PDMP") on a quarterly basis for the Respondent's CDS prescriptions. The administrative subpoenas may request a review of the Respondent's CDS prescriptions from the beginning of each quarter;

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

ORDERED that, after the appropriate hearing, if a disciplinary panel determines that the Respondent has failed to comply with any term or condition of this Consent Order, the disciplinary panel may reprimand the Respondent, place the Respondent on probation

with appropriate probationary terms and conditions, or suspend or revoke the Respondent's license to practice medicine in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

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

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

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

July 27, 2018
Date

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

CONSENT

I, Kwang B. Lee M.D., acknowledge that I have been apprised of my right to counsel and after conferring with counsel have agreed to enter into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree not to challenge the Findings of Fact, Conclusions of Law, and Order set forth in this Consent Order. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed after any such hearing.

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

Signature on File

07/25/18

Date

Kwang B. Lee, M.D.
Respondent

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF Howard

I HEREBY CERTIFY that on this 25 day of July 7, 2018, before me, a Notary Public of the foregoing State and City/County personally appear Kwang B. Lee, 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 notary seal.

Notary Public

My commission expires: 4/20/2021