IN THE MATTER OF	*	**BEFORE THE**
PETER BRUCE SHERER, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D21910	*	**Case Number: 2221-0043 B**

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

CONSENT ORDER

On July 16, 2021, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") charged **Peter Bruce Sherer, M.D.** (the "Respondent"), License Number D21910, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. §§ 14-101 *et seq.* (2014 Repl. Vol. & 2020 Supp.).

Specifically, Panel B charged the Respondent with violating the following provisions of the Act under Health Occ. § 14-404:

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (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 September 15, 2021, 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, Order, and Consent.

FINDINGS OF FACT

Panel B finds the following:

Background

1. At all relevant times, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent originally was licensed to practice medicine in Maryland on March 16, 1978, under License Number D21910. The Respondent's medical license is active through September 30, 2023.

2. The Respondent is board-certified in internal medicine, hematology, and medical oncology.

3. At all relevant times, the Respondent practiced at a medical office in Montgomery County, Maryland. The Respondent has privileges at two local hospitals.

Referral from the Maryland Office of Controlled Substances Administration

4. The Board initiated an investigation of the Respondent after receiving a referral, dated September 11, 2020, from the Maryland Office of Controlled Substances Administration ("OCSA"). In its referral, OCSA stated that in its professional judgment, the Respondent was prescribing "high doses of opioids (much higher than maximum recommended doses per CDC) and concurrently prescribed opioids with benzodiazepines and/or carisoprodol (increasing the risk of overdose death)."

Respondent's Written Response

5. By letter dated October 16, 2020, the Board informed the Respondent that it had opened an investigation of him after receiving the OCSA's referral. The Board requested that the Respondent address the matter in a written response.

6. By letter to the Board received on October 26, 2020, the Respondent addressed the concerns the OCSA raised in its referral. The Respondent stated he "rarely started a patient on narcotics," and that for the "10 cases [the Board] have selected for review, all of the patients were already on narcotics when they first came to me." The Respondent further stated he has "endeavored to reduce or stop these narcotics," and "tried to get these patients into pain management as well as referring them to appropriate specialists." The Respondent also stated on "multiple occasions, [he has] discharged patients from my practice for noncompliance and other red flag issues," including "two of the requested 10 patients" and was "in the process of discharging a third patient." The Respondent stated his "only failing is being a trusting and compassionate physician in dealing with patients who are in pain." On January 5, 2021, the Respondent provided a supplemental response in which he updated the Board regarding several patients he either discharged from his practice or referred to specialists.

Respondent's Board Interview

7. On January 14, 2021, Board staff conducted an under-oath interview of the Respondent. The Respondent stated that he provides chronic pain treatment for approximately 25 patients. The Respondent stated that for over 40 years, he has been

treating patients "on and off" for pain management. While the Respondent stated he has had "a lot of training in pain," he does not "hold [himself] out as a pain specialist."

8. The Respondent testified "[a]ll the patients [he has] seen for pain have already been on narcotics from another doctor." When he first sees such patients at his practice, he tries to "access where the pain is, what brings it on, what relives" and refers "[v]irtually everybody" to "pain management." The Respondent stated that when initially evaluating these patients, he will "at first...keep them what they're on, and then try to get them to reduce." The Respondent stated he tries to encourage his chronic pain management patients to taper their medications but "it's difficult in a lot of these people. Some people are very resistant to reducing."

9. The Respondent stated he usually sees his chronic pain management patients monthly in 15-minute follow-up appointments. The Respondent also stated he regularly checks the PDMP ("Prescription Drug Monitoring Program") or CRISP ("Chesapeake Regional Information System for our Patients") to ensure medication compliance for his chronic pain management patients. The Respondent also states he utilizes controlled substance contracts with his chronic pain management patients but they are "not worth the paper it's printed on." The Respondent stated he conducts urine toxicology screenings at least every three (3) months for his chronic pain management patients.

10. The Respondent stated that despite referring these patients for pain management, not "everybody can go because they can't find pain management that takes their specific insurance. There's no pain management person near them. And oftentimes,

my hope is that the pain management doctor will take over their narcotic prescribing because I don't like doing it." As such, the Respondent stated he would "like the guidance of the Board in what I can do. You know, I've dismissed a lot of these patients. I'd be happy to get rid of all these people...It's a hassle."

11. The Respondent stated "most of these patients legitimately have pain" and he is "just trying to help people the best I can." The Respondent stated his "only crime is being a compassionate doctor."

Peer Review

12. As part of its investigation, the Board issued a subpoena to the Respondent for ten (10) patient records and supporting materials and ordered a practice review (referred to *infra* as "Patients 1 through 10").[1] The review was performed by two physicians who are board-certified in anesthesiology with subspecialty certifications in pain medicine. The patients whose cases were reviewed were adult male and female patients who presented with chronic pain complaints. The Respondent maintained these patients, sometimes for multiple years, on combinations of high-dose opioids (*i.e.*, 90 to 540 MME),[2] often in conjunction with other scheduled medications such as benzodiazepines and/or carisoprodol. The reviewers independently concluded that in all ten cases reviewed, the Respondent failed to meet appropriate standards for the delivery of quality medical care and/or failed to keep adequate medical records.

[1] For confidentiality reasons, the names of patients have not been disclosed in this Consent Order.
[2] MME stands for morphine milligram equivalents.

13. Specifically, the reviewers found the Respondent failed to meet appropriate standards for the delivery of quality medical care and/or failed to keep adequate medical records in that the Respondent:

(a) failed to ensure compliance with opioid therapy through the documentation and use of controlled substance contracts, performance or documentation of urine toxicology screenings at required intervals, and/or performance or documentation of random pill counts (Patients 2, 3, 4, 5, 6, 7, 8, 9, 10);

(b) failed to document or perform appropriate work-up, diagnostic imaging and testing, treatments and referrals to appropriate specialists to justify the prescribing of opioids and other potent medications (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10);

(c) failed on a consistent basis to maintain adequate medical records for patients on chronic opioid therapy, including not documenting or performing pain-related physical examinations, appropriate histories, diagnoses, assessments, and/or treatment plans (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10);

(d) repeatedly reissued without adequate safeguards opioid prescriptions for patients who reported their medications were lost and/or stolen, and/or received prescriptions from multiple health care providers (Patients 2, 5, 6, 7, 8); and

(e) Prescribed excessive dosages of opioids (Patient 5).

14. The Board subsequently provided the reports from the peer reviewers to the Respondent, who submitted a response to those reports in a letter dated May 18, 2021. In his response, the Respondent provided a brief update on the status of the ten (10) patients selected for the practice review. The Respondent defended his treatment of these ten (10) patients, stating he "tried to get all of these patients into pain management," did not "start any of these patients on narcotics" and "tried to use the lowest doses possible." The Respondent stated he has "prescribed alternative modalities," has "been aware of red flags," has dismissed patients from my practice" and "appropriately referred patients" to other specialists.

15. The Respondent re-iterated that he does "not enjoy doing pain management and would be more than happy to have these patients reassigned to another physician or have a pain management physician take control." The Respondent further stated that he "would also be willing to sign a letter agreeing not to prescribe narcotics except for cancer or sickle cell patients."

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, Disciplinary Panel B of the Board concludes as a matter of law that the Respondent failed 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, in violation of Health Occ. § 14-404(a)(22), and failed to keep adequate medical records as determined by appropriate peer review, in violation of Health Occ. § 14-404(a)(40).

ORDER

It is, thus, 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 and dispensing all opioids; and it is further

ORDERED that any Delegation Agreement to which the Respondent is subject shall be modified to prohibit the Respondent from supervising Physician Assistants in their prescribing of opioids as limited by this Order; and it is further

ORDERED that the prohibition on prescribing and dispensing goes into effect ten (10) calendar days after the effective date of this Consent Order; and it is further

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

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

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

(2) the alleged violation will be adjudicated pursuant to the procedures of a Show Cause Hearing; and it is further

ORDERED that the Respondent is permanently prohibited from certifying patients for the medical use of cannabis; and it is further

ORDERED that on every January 31st thereafter if the Respondent holds a Maryland medical license, the Respondent shall provide the Board with an affidavit verifying that the Respondent has not certified patients for the medical use of cannabis in the prior year; and it is further

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

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

(2) the alleged violation will be adjudicated pursuant to the procedures of a Show Cause Hearing; and it is further

ORDERED that the disciplinary panel may issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program for the Respondent's Controlled Dangerous Substances ("CDS") prescriptions; and it is further

ORDERED that the Respondent is placed on **PROBATION** until he has completed the terms and conditions of probation.[3] During probation, the Respondent shall comply with the following terms and conditions of probation:

Within **SIX (6) MONTHS**, the Respondent is required to take and successfully complete a course in medical recordkeeping. The following terms apply:

(a) it is the Respondent's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the courses before the course is begun;

(b) the Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the courses;

(c) the course may not be used to fulfill the continuing medical education credits required for license renewal; and

(d) the Respondent is responsible for the cost of the courses.

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

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

[3] If the Respondent's license expires during the period of probation, the probation and any conditions will be tolled.

ORDERED that a violation of probation constitutes a violation of the Consent Order; and it is further

ORDERED that, if the Respondent allegedly fails to comply with any term or condition imposed by this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If the disciplinary panel determines there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings followed by an exceptions process before a disciplinary panel; and if the disciplinary panel determines there is no genuine dispute as to 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 the disciplinary panel determines that the Respondent has failed to comply with any term or condition imposed by this Consent Order, the disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke the Respondent's license to practice medicine in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on the Respondent; and it is further

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

ORDERED that the effective date of the Consent Order is the date the Consent Order is signed by the Executive Director of the Board or her designee. The Executive Director signs the Consent Order on behalf of the disciplinary panel which has imposed the terms and conditions of this Consent Order, and it is further

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

10/05/2021

Date

Signature on File

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

CONSENT

I, Peter B. Sherer, M.D., acknowledge that I have consulted with counsel before signing this document. By this Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition. I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 14-405 and Md. Code Ann., State Gov't §§ 10-201 *et seq*. concerning the pending charges. I waive these rights and have elected to sign this Consent Order instead.

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

I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order. I sign this Consent Order, without reservation, and fully understand the language and meaning of its terms.

9/29/21
Date

Signature on File
Peter B. Sherer, M.D.
Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Carroll

I HEREBY CERTIFY that on this 29 day of September, 2021, before me, a Notary Public of the State and County aforesaid, personally appeared Peter B. Sherer, M.D., and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

SHEILA RENAE DIGGS NOTARY PUBLIC CARROLL COUNTY, MD

Notary Public

My Commission Expires: 4/29/2023