IN THE MATTER OF	*	**BEFORE THE**
MICHAEL A. HYLE, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D27693	*	**Case Number: 2217-0098B**

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

CONSENT ORDER

PROCEDURAL BACKGROUND

On June 7, 2018, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") charged **MICHAEL A. HYLE, M.D.** (the "Respondent"), License Number D27693, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2014 Repl. Vol. and 2017 Supp.).

Disciplinary Panel B charged the Respondent with violating the following provision of the Act under Health Occ. § 14-404:

> (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:
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> . . .
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> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State[.]

On October 17, 2018, a hearing was held before Panel B, sitting as a Disciplinary Committee for Case Resolution. As a result of negotiations occurring before Panel B, the Respondent agreed to enter into the following Consent Order, consisting of

Procedural Background, Findings of Fact, Conclusions of Law, Order, Consent and Notary.

FINDINGS OF FACT

Panel B makes the following Findings of Fact:

I. Licensing Information

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on March 11, 1982, under License Number D27693. The Respondent's license is currently active and is scheduled for renewal on September 30, 2018.

2. The Respondent is not board-certified in any medical specialty.

3. At all times relevant hereto, the Respondent maintained a medical office at 6530 Walther Avenue, Baltimore, Maryland 21206.

II. The Complaint

4. On or about March 1, 2017, the Board received an anonymous complaint against the Respondent, dated February 27, 2017, from an individual (the "Complainant") who reported that a male patient ("Patient E," *infra*)[1] in his early 70s was admitted to a health care facility (the "Facility") after a fall in which he sustained orbital trauma.

5. The Complainant reported that Patient E was persistently delirious from admission to discharge (February 20 to 24, 2017), and that his likely etiology was "polypharmacy, benzodiazepine and opiate withdrawal."

[1] For confidentiality reasons, the names of patients or health care facilities have not been identified in this document. The Respondent is aware of the identity of all patients and health care facilities referenced herein.

6. The Complainant stated that the "patient's pharmacies were called and CRISP PDMP[2] was interrogated to get a clear understanding of his medication intake." The Complainant reported that this inquiry revealed that for a period of years, Patient E was prescribed high dosages of short and long acting Schedule II opioid medications (oxycodone and OxyContin, respectively), Schedule IV benzodiazepines (Xanax, 0.25 mg, five-to-seven per day), and a Schedule IV sedative-hypnotic (Ambien 10 mg). The Complainant stated that during his hospitalization, Patient E was treated for withdrawal.

III. Investigative Findings

7. After reviewing the above complaint, the Board initiated an investigation of the Respondent. Pursuant to its investigation, the Board obtained ten patient records from the Respondent and submitted them to two physicians who are board-certified in anesthesiology with sub-specialty certifications in pain medicine for a practice review. The reviewers determined that the Respondent failed to meet appropriate standards for the delivery of quality medical care in five cases ("Patients A through E").

8. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), with respect to Patients A through E. In these cases, the Respondent prescribed high dosages of opioid medications, sometimes in combination with benzodiazepines, for extended periods of time, without appropriate indication. While prescribing these medications, the Respondent did not employ pain management agreements in some cases, and in all cases did not employ treatment compliance measures, such as toxicology screening, pill counts or pharmacy queries, or undertake a risk stratification analysis for drug

[2] CRISP stands for "Chesapeake Regional Information on our Patients." PDMP stands for "Prescription Drug Monitoring Program."

abuse. In the cases reviewed, the Respondent engaged in other inappropriate practices, including instances where he failed to appropriately address "red flag" behaviors and provided undated opioid prescriptions for his patients to fill in. Deficiencies cited are in the following patient summaries:

Patient A

9. The Respondent began providing medical care to Patient A, a man then in his mid-40s, in or around December 2012. Patient A claimed that he had joint and muscle pain for greater than two years and that he had been taking oxycodone (an opioid and Schedule II controlled dangerous substance ("CDS")) 15 mg, three-to-four times per day. In a summary of care the Respondent provided, the Respondent stated that Patient A's "previous doctor had him on 5 a day of oxycodone 15 mg and we reduced it to 4 a day but no lower." Patient A reportedly underwent a previous rheumatologic and neurologic evaluation, with only minor findings of nonspecific sensory neuropathy.

10. From Patient A's initial visit, occurring in or around December 2012, to in or around June 2017, the Respondent saw Patient A on a monthly basis, during which time he prescribed opioid pain medications (typically oxycodone 15 mg, four times per day) to treat Patient A's complaints of chronic shoulder and back pain, myalgias, and neuropathy.

11. In or around February 2013, the Respondent recommended a referral for a pain management consultation, which Patient A declined, purportedly due to financial considerations. In or around April 2013, the Respondent ordered an MRI, which revealed mild rotator cuff tendonitis and arthritic of the AC (acromioclavicular) joint.

12. In or around April 2013, the Respondent placed Patient A on a fentanyl patch (75 mcg/hr) once every 72 hours (fentanyl is an opioid and Schedule II CDS), in addition to prescribing oxycodone. Patient A reported that he had trouble with the patches adhering, after which the Respondent gave him additional prescriptions to fill if the patches did not stick.

13. In or around August 2013, the Respondent had Patient A sign a pain management agreement.

14. In or around September 2013, Patient A was involved in an automobile accident, after which he asked the Respondent to decrease his pain medication. The Respondent weaned Patient A from the fentanyl patches but continued prescribing oxycodone 15 mg four times per day, until in or around June 2017.

15. During the course of care, the Respondent also prescribed Soma, a muscle relaxant and Schedule IV CDS. The Respondent's records also indicate that he prescribed other prescription-only, anti-depressant medications, including trazadone and Zoloft.

16. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), with respect to Patient A, for reasons including:

(a) the Respondent failed to appropriately examine or evaluate Patient A for his pain complaints while prescribing high dosages of opioid pain medications;

(b) the Respondent prescribed excessive dosages of opioid pain medications;

(c) the Respondent prescribed combinations of Schedule II opioid medications (*e.g.*, oxycodone and fentanyl patches) without appropriate indication or documented rationale;

(d) the Respondent failed to employ appropriate treatment compliance measures, such as urine toxicology screening, pill counts or pharmacy queries;

(e) the Respondent failed to document or undertake a risk stratification analysis for risk of opioid abuse. Patient A had a history of alcohol abuse, multiple alcohol-related driving charges and a positive family history of drug abuse; and

(f) the Respondent failed to recognize or address "red flag" behaviors, including Patient A's claim of misplaced or stolen oxycodone medications. The Respondent failed to provide counseling regarding this incident, despite it being a violation of Patient A's pain management agreement.

Patient B

17. The Respondent began providing medical care to Patient B, a woman then in her 40s, in or around December 2014. The Respondent continued to provide medical care to Patient B on a monthly or bi-monthly basis until in or around June 2017. The Respondent saw Patient B on approximately 17 patient visits during this interval.

18. During her initial visit on December 29, 2014, Patient B reported complaints of shoulder and neck pain, and a prior medical history that included a gastric bypass. The Respondent prescribed hydrocodone 5 mg (an opioid and Schedule II

CDS), Skelaxin (a muscle relaxant) and Motrin 800 mg for the pain and instructed her to see an orthopedic physician if the pain did not improve.

19. In or around January 2015, Patient B underwent an orthopedic evaluation, which recommended that she undergo an MRI prior to starting a physical therapy program. Patient B declined to undergo the imaging studies or physical therapy, however.

20. In or around February 2015, Patient A returned for treatment to the Respondent, who continued her on hydrocodone 5 mg, Skelaxin and Motrin 800 mg.

21. In or around May 2015, the Respondent noted that Patient B had a decreased hemoglobin and hematocrit but no signs of gastrointestinal ("GI") issues.

22. In or around September 2015, Patient B reported acute stress and anxiety, after which the Respondent added Xanax 0.25 mg (a Schedule IV CDS), four times per day to her existing medication regimen.

23. In or around October 2015, Patient B reported abdominal pain, vomiting and nausea, after which the Respondent increased Patient B's hydrocodone dosage (7.5 mg, four times per day) discontinued her ibuprofen and referred her for a GI consultation. Patient B was diagnosed with an acute gastric ulcer.

24. In or around February 2016, the Respondent restarted Patient B on ibuprofen in small amounts for pain, with instructions to discontinue if the epigastric pain returned.

25. In or around May 2016, the Respondent began giving Patient B two prescriptions for hydrocodone at each visit, one to fill immediately, and one that was

undated, to be filled the next month. The Respondent continued this prescription regimen throughout the treatment interval.

26. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), with respect to Patient B, for reasons including:

(a) the Respondent inappropriately prescribed ibuprofen 800 mg, in view of Patient B's history of gastric bypass surgery. When anemia was found, the Respondent inappropriately maintained Patient B on this non-steroidal anti-inflammatory ("NSAID") medication. After Patient B developed an acute ulcer, the Respondent inappropriately resumed the prescribing of NSAIDs;

(b) the Respondent failed to require a pain management agreement for Patient B, for whom he prescribed opioid medications for an extended time period;

(c) the Respondent failed to employ appropriate treatment compliance measures, such as urine toxicology screening, pill counts or pharmacy queries;

(d) the Respondent inappropriately prescribed opioid medications without appropriate justification, and inappropriately escalated dosages of opioid medications during the treatment interval;

(e) the Respondent failed to document or undertake a risk stratification analysis for risk of opioid abuse; and

(f) the Respondent inappropriately provided several undated opioid prescriptions to Patient B, which she was allowed to date when she filled them.

Patient C

27. The Respondent began providing medical care to Patient C, a man then in his 60s, in or around 2012. The Respondent treated Patient C for various conditions, including coronary artery disease with two myocardial infarctions, diabetes mellitus, obstructive sleep apnea, tachycardia, congestive heart failure, a transient ischemic attack, chronic obstructive pulmonary disease and prostate issues.

28. In or around May 2015, Patient C presented to the Respondent complaining of left cervical radiculopathy. Patient C reported that a family member gave him his unused OxyContin 10 mg, which he was taking for the pain. OxyContin is a long-acting opioid medication and Schedule II CDS. The Respondent noted that Patient C sought pain management treatment but "they were unable to give him a shot because he was on Plavix." The Respondent noted that Patient C was "here today seeking OxyContin 10 mg to take twice a day for his chronic radicular pain in his left neck and arm."

29. In response, the Respondent prescribed Patient C OxyContin 10 mg, with instructions to take one tablet twice per day. The Respondent had Patient C sign a pain management agreement during this visit. The Respondent's note also stated that Patient C had been placed on gabapentin (a prescription-only medication used to treat neuropathic pain) but did not tolerate it and was using a device on his arm daily for pain

relief. The Respondent's note does not indicate that he addressed other modalities to address Patient C's pain.

30. In or around July 2015, Patient C returned for care. In his note for this visit, the Respondent stated that Patient C requested that his OxyContin be discontinued. In response, the Respondent discontinued Patient C's OxyContin and placed him on oxycodone 5 mg, four times per day, with instructions to attempt to taper to three times per day. The Respondent continued to prescribe this regimen during monthly visits.

31. In an office note for a visit on June 7, 2016, the Respondent noted that Patient C "missed his appointment last week and ran out of his pain medicine and had (sic) borrow some from his [family member] who is also on oxycodone for pain." The Respondent's note for this date does not indicate that he counseled Patient C for opioid misuse or took any other action to address this misuse.

32. The Respondent continued to see Patient C on a monthly basis until June 2017, during which time he maintained him on oxycodone 5 mg, four times per day, with instructions to take two pills if he found "no relief."

33. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), with respect to Patient C, for reasons including:

(a) the Respondent failed to document or perform a physical examination for Patient C's chronic pain complaints prior to placing him on long-acting opioid medications. The Respondent failed to perform follow-up examinations to re-evaluate Patient C's chronic pain complaints;

(b) the Respondent failed to document or counsel Patient C when he reported that he was using a family member's OxyContin;

(c) the Respondent inappropriately placed Patient C on a long-acting opioid medication, as no records substantiated that Patient C had previously used opioid medications;

(d) the Respondent failed to employ appropriate treatment compliance measures, such as urine toxicology screening, pill counts or pharmacy queries, particularly since Patient C requested opioids and admitted to misusing opioids that had been prescribed to others;

(e) the Respondent failed to document or attempt other modalities to treat Patient C's chronic pain complaints prior to resorting to use of a long-acting opioid medication;

(f) the Respondent failed to document or address Patient C's violation of his pain management agreement when Patient C admitted taking opioid medications that had not been prescribed for him, which was specifically prohibited under his pain management agreement. The Respondent failed to document or provide counseling for this violation or discontinue prescribing the medications in response to his violation of the agreement; and

(g) the Respondent failed to document or undertake a risk stratification analysis for risk of opioid abuse.

Patient D

34. The Respondent began providing medical care to Patient D, a woman then in her 40s, sometime in the late 1980s. Patient D had complex medical problems including diabetes mellitus, hypothyroidism and hypertension. Patient D had a complex medical illness that was difficult to characterize by several specialists but was thought to be vasculitis neuropathy that caused pain and numbness in Patient D's extremities. For this, the Respondent, as early as March 2009, began treating Patient D with Cymbalta (a prescription-only medication used for a variety of conditions including depression, anxiety, fibromyalgia and neuropathic pain), gabapentin and opioid pain medications. Patient D was also taking steroids under the guidance of her specialists, including rheumatologists and neurologists.

35. During the course of care, which continued until 2017, the Respondent treated Patient D for various medical conditions, including atypical face pain, peripheral neuropathy, and vasculitis of an autoimmune source.

36. From in or around August 2014 to in or around March 2016, the Respondent prescribed hydrocodone 5 mg on an indeterminant basis.

37. Beginning in or around March 2016, and continuing until in or around June 2017, the Respondent placed Patient D on OxyContin 15 mg, twice per day, and in some of the entries, oxycodone 10 mg, four times per day. The Respondent's records indicate that as of May 2017, he discontinued Patient D's OxyContin 15 mg and added OxyContin 20 mg to his prescribing regimen. The Respondent's handwritten notes and a narrative summary he provided to the Board indicate that he was also prescribing oxycodone 10 mg, once every four-to-six hours.

38. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), with respect to Patient D, for reasons including:

(a) the Respondent inappropriately provided chronic opioid therapy for Patient D's conditions;

(b) the Respondent failed to require a pain management agreement for Patient D, for whom he prescribed opioid medications for an extended time period;

(c) the Respondent failed to employ appropriate treatment compliance measures, such as urine toxicology screening, pill counts or pharmacy queries;

(d) the Respondent failed to document or undertake a risk stratification analysis for risk of opioid abuse;

(e) the Respondent's treatment records are unclear, as they indicate that Patient D was seeing other specialists who describe pain medications that were suggested or prescribed; and

(f) the Respondent's treatment records indicate extensive gaps (*e.g.*, October 28, 2016 to May 1, 2017), during which time the Respondent provided opioid treatment without evaluating Patient D for proper use or efficacy of the medications prescribed.

Patient E

39. The Respondent began providing medical care to Patient E, a man currently in his 70s, in or around 1994. The Respondent treated Patient E for conditions

including coronary artery disease, hypertension, hypothyroidism, diabetes, kidney stones, anxiety and chronic back pain. Throughout the course of care, which continued until in or around July 2017, the Respondent maintained Patient E for over 15 years on high dosages of opioid medications and benzodiazepines.

40. As of early 2017 (the time period during which Patient E was hospitalized for injury/delirium), the Respondent was maintaining Patient E on OxyContin 20 mg, two tablets every eight hours; oxycodone 5 mg, two tablets every six hours; Xanax 0.25 mg, three times per day; and Ambien 10 mg, one tablet at bedtime.

41. Throughout Patient E's medical record, the Respondent noted difficulty obtaining his prescribed amounts of opioid medications, due to quantity limits set by Patient E's insurance company for safety reasons. For example, in May 2014, Patient E's insurance company sent the Respondent a notice with a weaning schedule. Despite this, the Respondent did not wean Patient E from his high-dosage opioid regimen and escalated it further. The quantity limits the insurance company placed were OxyContin 20 mg (540 tablets) and oxycodone 5 mg (360 tablets) for a 90-day supply. In October 2015, the Respondent prescribed OxyContin 20 mg, two tablets every eight hours and oxycodone 5 mg, one-to-two tablets every six hours, with a dispensed quantity of 540 tablets of each medication for a 90-day supply.

42. There were instances where the Respondent supplied Patient E with extra OxyContin prescriptions, which Patient E paid cash at local pharmacies due to quantity limits set forth by his insurance provider.

43. In or around January 2017, the Respondent referred Patient E to a pain medicine specialist, who recommended a weaning schedule. As of June 2017,

however, Patient E had not weaned down according to the schedule the pain medicine specialist provided.

44. When Patient E was hospitalized in February 2017 (see ¶ 4-5, *supra*), the Xanax was weaned and discontinued due to Patient E's altered mental status, and his OxyContin was decreased. Upon his discharge, however, Patient E did not comply with his weaning schedule and was still utilizing his OxyContin and oxycodone, while continuing to take up to five tablets of Xanax per day. The Respondent's records are unclear as to whether he discontinued prescribing the Xanax, as the Respondent's electronic medical records continued to show that Xanax was still on Patient E's active medication list.[3]

45. Patient E's chart indicates behaviors consistent with opioid misuse, including citations for erratic driving and multiple notations that Patient E appeared to be unsteady on his feet on physical examination.

46. Patient E's chart also indicates that he was experiencing mental health issues (*e.g.*, October 2015). The Respondent increased Patient E's Xanax 0.25 mg prescription to two tablets every four-to-six hours for his increased anxiety, rather than referring him for mental health counseling.

47. In an interview provided to Board staff, the Respondent admitted that he provided at least three or four undated prescriptions to Patient E.

48. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), with respect to Patient E, for reasons including:

[3] Patient E's progress notes for this period do not indicate that the Respondent wrote Xanax prescriptions for Patient E, however.

(a) the Respondent inappropriately prescribed excessive dosages of opioid medications, benzodiazepines and sedative-hypnotics for Patient E's medical conditions;

(b) the Respondent failed to require a pain management agreement for Patient E, for whom he prescribed opioid medications for an extended time period;

(c) the Respondent failed to employ appropriate treatment compliance measures, such as urine toxicology screening, pill counts or pharmacy queries;

(d) the Respondent failed to document or undertake a risk stratification analysis for risk of opioid abuse;

(e) the Respondent failed in a meaningful way to wean Patient E from his opioid/benzodiazepine prescribing regimen, despite instructions from Patient E's insurance carrier, a pain medicine consultant's recommendation, and Patient E's hospitalization in February 2017 for drug-related delirium/trauma; and

(f) the Respondent inappropriately gave undated prescriptions to Patient E.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel B finds as a matter of law that the Respondent violated 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 performed in an outpatient surgical facility, office, hospital, or any other location in this State.

ORDER

It is thus by Disciplinary Panel B of the Board, hereby:

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

ORDERED that the Respondent is placed on probation for a minimum period of two (2) years.[4] During probation, the Respondent shall comply with the following terms and conditions of probation:

1. The Respondent is required to take a course in the appropriate prescribing of opioid medications. The following terms apply:

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

   (b) the disciplinary panel will not accept a course taken over the internet;

   (c) the Respondent shall enroll in and successfully complete a panel-approved course within six months;

   (d) the Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the course;

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

   (f) the Respondent is responsible for the cost of the course.

2. During probation the Respondent is prohibited from prescribing or dispensing:

   (a) all opioids;

   (b) in emergency cases, the Respondent may issue no more than one prescription for a drug listed above for each patient

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

during the probationary period, but the prescription may not exceed the lowest effective dose and quantity needed for a duration of five days. The prescription may not be refilled, nor may it be renewed. The Respondent shall notify the Board within 24 hours of any prescription written as authorized by this paragraph;

(c) benzodiazepines to any patient prescribed opioids as outlined in (b), above; and

(d) the Respondent is prohibited from delegating to a Physician Assistant the prescription of the above prohibited substances.

3. During probation the Respondent is prohibited from certifying patients for the medical use of cannabis.

4. The Respondent is subject to a chart and/or peer review conducted by the disciplinary panel or its agents as follows:

(a) the Respondent shall cooperate with the peer review process;

(b) the disciplinary panel in its discretion may change the focus of the peer review if the Respondent changes the nature of his or her practice;

(c) if the disciplinary panel, upon consideration of the peer review and the Respondent's response, if any, determines that the Respondent is meeting the standard of quality care in his or her practice, the disciplinary panel shall consider the peer review condition of the Consent Order met; and

(d) if the disciplinary panel, upon consideration of the peer review and the Respondent's response, if any, has a reasonable basis to believe that the Respondent is not meeting the standard of quality care in his or her practice or cannot safely and competently practice, the disciplinary panel may charge the Respondent with a violation of probation and/or under the Medical Practice Act.

5. The disciplinary panel may issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program on a quarterly basis for the Respondent's Controlled Dangerous Substances ("CDS") prescriptions. The

administrative subpoena will request the Respondent's CDS prescriptions from the beginning of each quarter.

6. Within five business days of the date of this Consent Order, the Respondent shall inform the Board in writing of his or her current employer or employers, the employer's or employers' address or addresses, and of all locations including hospitals at which the Respondent provides health care services. The Respondent shall keep the Board informed of any subsequent employment changes within five business days of the change.

7. The Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101—14-702, and all federal and state laws and regulations governing the practice of medicine in Maryland.

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

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

ORDERED that after the Respondent has complied with all terms and conditions of probation and the minimum period of probation imposed by the Consent Order has passed, the Respondent may submit a written petition for termination of probation. After consideration of the petition, the probation may be terminated through an order of the disciplinary panel. The Respondent may be required to appear before the disciplinary panel to discuss his or her petition for termination. The disciplinary panel may grant the

petition to terminate the probation, through an order of the disciplinary panel if there are no pending complaints relating to the charges; 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 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 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 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 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 the Respondent is responsible for all costs incurred in fulfilling 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).

11/07/2018
Date

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

CONSENT

I, Michael A. Hyle, 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 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 their 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 understands the language and meaning of its terms.

Signature on File

10/30/2018
Date

Michael A. Hyle, M.D.
Respondent

Read and approved:

Neal M. Brown, Esquire
Counsel for Dr. Hyle

NOTARY

STATE OF Maryland

~~CITY~~/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 30th day of October 2018, before me, a Notary Public of the foregoing State and City/County, personally appeared Michael A. Hyle, M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

Karen J. Miller
Notary Public

My Commission expires: 12/2/19