IN THE MATTER OF	*	**BEFORE THE**
VICKEN POOCHIKIAN, M.D.	*	**MARYLAND STATE**
Respondent.	*	**BOARD OF PHYSICIANS**
License Number: D34722	*	**Case Number: 2017-0267**

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

FINAL DECISION AND ORDER

PROCEDURAL HISTORY

On June 19, 2018, Disciplinary Panel B of the Maryland State Board of Physicians ("Board") charged Vicken Poochikian, M.D., with unprofessional conduct in the practice of medicine and with practicing medicine with an unauthorized person or aiding an unauthorized person in the practice of medicine. *See* Md. Code Ann., Health Occ. § 14-404(a)(3)(ii), (18). Dr. Poochikian was charged with violating the Code of Maryland Regulations ("COMAR") pertaining to Delegation and Assignment of Performance of Cosmetic Medical Procedures and Use of Cosmetic Medical Devices. COMAR 10.32.09.04A. The charges alleged that, as medical director for a facility, Dr. Poochikian directly and indirectly supervised unlicensed individuals performing cosmetic medical procedures, such as laser hair removal.

On March 28, 2019, an Administrative Law Judge ("ALJ") held an evidentiary hearing at the Office of Administrative Hearings. At that hearing, the State introduced exhibits and the parties stipulated to certain facts. Dr. Poochikian testified on his own behalf. On June 26, 2019, the ALJ issued a proposed decision recommending that the Board uphold the charges that Dr. Poochikian was guilty of unprofessional conduct in the practice of medicine and practiced medicine with an unauthorized person and aided an unauthorized person in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii), (18). The ALJ recommended that Dr.

Poochikian be reprimanded and ordered to pay a $20,000 fine. Dr. Poochikian filed written exceptions, and the State filed a response. On September 11, 2019, Disciplinary Panel A ("Panel A") held an oral exceptions hearing.

FINDINGS OF FACT

Panel A adopts the Stipulated Facts, the ALJ's Proposed Findings of Fact, and the Discussion section of the ALJ's Proposed Decision. The Stipulated Facts ¶¶ 1-18, the ALJ's Proposed Findings of Fact ¶¶ 1-22, and the Discussion (pages 11-16) are incorporated by reference into the body of this document as if set forth in full. *See* attached ALJ Proposed Decision, Exhibit 1. The stipulated facts and findings of fact were proven by a preponderance of the evidence and are summarized below.

Dr. Poochikian has been licensed to practice medicine in Maryland since February 18, 1987. From approximately April 2015 until August 2016, Dr. Poochikian served as medical director and co-owner of a clinic (the "Facility") that performed medical and cosmetic injections, laser hair removal, facials, esthetics, and weight-loss management. During his time at the Facility, in addition to his role as medical director, Dr. Poochikian performed Botox procedures and supervised unlicensed technicians who performed cosmetic medical procedures including laser hair removal. None of the technicians or estheticians who worked at the Facility were licensed under the Health Occupations Article to perform laser hair removal or other cosmetic medical procedures.1 The Facility's technicians and estheticians routinely performed cosmetic

1 According to Maryland regulations, a "cosmetic medical procedure may be delegated to a . . . health care provider licensed under [the] Health Occupations Article[.]" COMAR 10.32.09.04A. "'Cosmetic medical procedure' means a procedure using a cosmetic medical device or medical product to improve an individual's appearance" and includes "skin treatment using lasers." COMAR 10.32.09.02B(5). Cosmetic medical device also includes using a laser for cosmetic purposes. COMAR 10.32.09.02B(4). The Court of Special Appeals has upheld the Board's conclusion that use of lasers for hair removal is a surgical act that is encompassed in the statutory definition of the practice of medicine. *Mesbahi v. Board of Physicians*, 201 Md. App. 315, 335 (2011).

medical procedures, including laser hair removal, on patients when Dr. Poochikian was not in the treatment room and when he was not at the Facility. Dr. Poochikian testified at the hearing that, in January 2016, he became aware that the technicians were using the equipment in his absence. According to Dr. Poochikian, at that time, he informed his co-owner that he would resign, but he continued practicing at the Facility for an additional six months before finalizing his resignation. The ALJ found, however, that Dr. Poochikian was aware that unlicensed technicians and estheticians were performing cosmetic medical procedures in and outside his presence. During the six months before he ceased practicing at the Facility, an unlicensed technician continued to perform laser hair removal under Dr. Poochikian's direct supervision. In August 2016, Dr. Poochikian stopped appearing at the Facility and thus no longer provided on-site supervision of the laser hair removal procedures. Dr. Poochikian continued to serve as medical director for an additional period of months while cosmetic medical procedures including laser hair removal continued to be performed by unlicensed individuals (*see* Findings of Fact ¶¶ 17, 19, 20), but he no longer supervised laser hair removal treatments in-person. Dr. Poochikian's failed to supervise the cosmetic medical procedures performed at the Facility and he failed to monitor the Facility's use of its cosmetic medical device.

EXCEPTION – FINDING OF FACT

Dr. Poochikian argues in his exceptions that he only allowed an unlicensed female technician to perform laser hair removal when patients were female. However, in the ALJ's Proposed Decision's stipulated facts, an unlicensed female technician performed laser hair removal on a male patient (Patient 6), as well as female patients. *See* ALJ's Proposed Decision at 8.

CONCLUSIONS OF LAW

Disciplinary Panel A concludes, as a matter of law, that Dr. Poochikian is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii), delegated cosmetic medical procedures to an individual who was not licensed by the Health Occupations Article, in violation of COMAR 10.32.09.04A, and practiced medicine with an unauthorized person or aided an unauthorized person in the practice of medicine, in violation of Health Occ. § 14-404(a)(18).

EXCEPTIONS - SANCTION

In his exceptions to the proposed sanction, Dr. Poochikian concedes that he is "technically in violation of certain Sections of the Maryland Medical Practice Act." He admits that "by permitting hair laser removal . . . under his supervision, he understands now that that was contrary to his obligations." Dr. Poochikian, however, presents several arguments in mitigation of his violation and argues that he should receive a less severe sanction.

First, Dr. Poochikian argues that he acted appropriately by resigning once he realized the Facility was acting in contravention of Maryland law. Second, Dr. Poochikian asserts that he only allowed female unlicensed individuals to perform laser hair removal when the patient was female and involved private parts. Third, he argues that the sanction of a reprimand and $20,000 fine is excessive and onerous.

In its response, the State argues that the ALJ's proposed decision was well-founded on the evidence introduced. The State notes that Dr. Poochikian's resignation did not occur until after he had already violated the statute. The State responds that, even if limited, Dr. Poochikian still violated the Medical Practice Act by supervising unlicensed individuals performing

cosmetic medical procedures. Finally, the State asserts that the proposed sanction was appropriate and within the sanctioning guidelines.

Dr. Poochikian argues that he acted appropriately by resigning his position, in January 2016, when he became aware that the Facility was "acting in a manner that was inappropriate" by treating patients for laser hair removal when he was not present. Dr. Poochikian states that his decision to resign is a mitigating factor that warrants a lesser sanction. Dr. Poochikian's resignation, however, was premised on his mistaken belief that allowing unlicensed individuals to perform laser hair removal was acceptable under direct supervision, but not under remote or indirect supervision. Indeed, between April 2015 and August 2016, before and after his decision to resign, Dr. Poochikian supervised laser hair removal treatment by unlicensed technicians and estheticians in contravention of the Maryland Medical Practice Act. His decision to resign, in January 2016, while he continued to allow an unlicensed technician to perform laser hair removal treatments under his supervision, does not mitigate his conduct.

Dr. Poochikian's second argument, that he only allowed female unlicensed technicians to perform laser hair removal on female patients, is incorrect. As discussed above, Dr. Poochikian supervised a female unlicensed technician who performed laser hair procedures on a male patient. Further, his excuse is irrelevant. The fact that he mostly practiced with unlicensed individuals for patients of the opposite sex does not excuse his conduct. This conduct is prohibited for all patients.

Finally, Dr. Poochikian argues that the sanction is excessive and onerous. For unprofessional conduct, the sanctioning guidelines recommend a sanction ranging from a reprimand to revocation and a fine of $5,000 to $50,000. For practicing medicine with an unauthorized person or aiding an unauthorized person in the practice of medicine, the

sanctioning guidelines recommend a sanction ranging from a reprimand to revocation and a fine $10,000 to $50,000. A reprimand is the most lenient sanction, and the proposed $20,000 fine falls in the middle of the sanctioning guidelines' range for the imposition of a fine.

Dr. Poochikian served as medical director and part owner of the Facility and directly supervised an unlicensed technician performing laser hair removal for more than 15 months. As a licensed physician, he was responsible for ensuring that the individuals he supervised performing the cosmetic medical procedures at the Facility were correctly licensed. The proposed fine is consistent with a similar Board case. *See Mesbahi v. Board of Physicians*, 201 Md. App. 315, 328 (2011) (affirming the Board's fine of a $20,000 for aiding unauthorized practice of medicine and unprofessional conduct, among other sanctions, by inappropriately delegating laser hair removal procedures to unlicensed individuals). As the ALJ stated, "[t]he potential for harm is immeasurable, and [Dr. Poochikian] was fortunate that no patient suffered great harm." Panel A adopts the ALJ's proposed sanction of a reprimand and $20,000 fine. Dr. Poochikian's exceptions are denied.

ORDER

It is, by an affirmative vote of a majority of a quorum of Disciplinary Panel A, hereby

ORDERED that Vicken Poochikian, M.D. is **REPRIMANDED**; and it is further

ORDERED that within **TWO YEARS**, Dr. Poochikian shall pay a civil fine of $20,000. The Payment shall be made by money order or bank certified check made payable to the Maryland Board of Physicians and mailed to P.O. Box 37217, Baltimore, Maryland 21297. The Board will not renew or reinstate Dr. Poochikian's license if Dr. Poochikian fails to timely pay the fine to the Board; and it is further

ORDERED that the effective date of the Final Decision and Order is the date the Final Decision and Order is signed by the Executive Director of the Board. The Executive Director signs the Final Decision and Order on behalf of Disciplinary Panel A; and it is further

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

11/13/2019
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. Poochikian 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. Poochikian 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
Maryland Department of Health
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

Exhibit 1

MARYLAND STATE BOARD OF	*	BEFORE MICHELLE W. COLE,
PHYSICIANS	*	AN ADMINISTRATIVE LAW JUDGE
v.	*	OF THE MARYLAND OFFICE
VICKEN POOCHIKIAN, MD,	*	OF ADMINISTRATIVE HEARINGS
RESPONDENT	*	OAH No.: MDH-MBP1-71-18-36532
LICENSE No.: D34722	*	

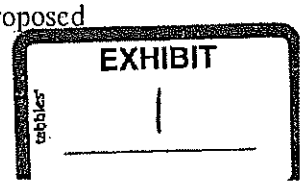
* * * * * * * * * * * * *

PROPOSED DECISION

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

STATEMENT OF THE CASE

On June 19, 2018, the Maryland Board of Physicians (Board) issued charges against Vicken Poochikian, M.D., (Respondent) based on alleged violations of the Maryland Medical Practice Act. Md. Code Ann., Health. Occ. §§ 14-101 through 14-702 (2014 & Supp. 2018). Specifically, the Respondent is charged with violating sections 14-404(a)(3)(ii) (unprofessional conduct in the practice of medicine); and 14-404(a)(18) (practicing medicine with an unauthorized person or aiding an unauthorized person in the practice of medicine). A Case Resolution Conference was held on October 17, 2018. Code of Maryland Regulations (COMAR) 10.32.02.03E(9). On November 27, 2018, the Respondent requested a hearing. The disciplinary panel to which the complaint was assigned forwarded the charges to the Office of the Attorney General for prosecution, and another disciplinary panel delegated the matter to the Office of Administrative Hearings (OAH) for issuance of proposed findings of fact, proposed



conclusions of law and a proposed disposition. COMAR 10.32.02.03E(5); COMAR 10.32.02.04B(1).

On December 21, 2018, I held a scheduling conference at the OAH in Hunt Valley, Maryland. Michael Brown, Assistant Attorney General and Administrative Prosecutor, represented the Board. Allen J. Kruger, Esquire, represented the Respondent. Mr. Brown was present at the OAH. Mr. Kruger and the Respondent participated by telephone.

On February 21, 2019,[1] I conducted a pre-hearing conference. I was located at the OAH in Hunt Valley, Maryland. Again, Mr. Brown represented the Board and Mr. Kruger represented the Respondent.

I held a hearing on March 28, 2019, at the OAH in Hunt Valley, Maryland. Health Occ. § 14-405(a) (Supp. 2018); COMAR 10.32.02.04. Mr. Kruger represented the Respondent, who was present. Mr. Brown represented the Board.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules for Hearings Before the Board, and the Rules of Procedure of the OAH. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2014 & Supp. 2018); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

Is the Respondent subject to sanction under section 14-404(a)(3) of the Medical Practice Act for unprofessional conduct in the practice of medicine?

Is the Respondent subject to sanction under section 14-404(a)(18) of the Medical Practice Act for practicing medicine with an unauthorized person or aiding an unauthorized person in the practice of medicine?

[1] The pre-hearing conference scheduled for February 20, 2019 was postponed due to a weather-related closure of the OAH.

If so, what sanctions are appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

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

Bd. Ex. 1	Anonymous Complaint, dated October 19, 2016
Bd. Ex. 2	Initial contact letter with Complainant, dated December 1, 2016
Bd. Ex. 3	Memo to file from Board Investigations, dated December 15, 2016
Bd. Ex. 4	Transcript of interview with [redacted],[2] dated February 24, 2017
Bd. Ex. 5	Photographs, dated August 17, 2017
Bd. Ex. 6	Memo to file regarding Board unannounced visit, dated August 17, 2017
Bd. Ex. 7	Initial contact letter to Respondent and copy of complaint, dated August 21, 2017
Bd. Ex. 8	Written response of Respondent and Information Form, dated August 25, 2017
Bd. Ex. 9	[redacted] (Facility) appointment logs, dated September 8, 2017
Bd. Ex. 10	Facility employee list, dated October 3, 2017
Bd. Ex. 11	Facility appointment logs, undated
Bd. Ex. 12	Facility patient records, various dates
Bd. Ex. 13	Transcript of interview with Respondent, dated October 12, 2017
Bd. Ex. 14	Facility Operating Agreement, dated April 30, 2015
Bd. Ex. 15	Transcript of interview with [redacted], dated October 16, 2017
Bd. Ex. 16	Memo to file from Board regarding unannounced visit, dated December 14, 2017
Bd. Ex. 17	Transcript of interview with [redacted], dated January 11, 2018
Bd. Ex. 18	Transcript of interview with [redacted], dated January 11, 2018
Bd. Ex. 19	Transcript of interview with [redacted], dated January 18, 2018
Bd. Ex. 20	Transcript of telephonic interview with [redacted], M.D., dated February 6, 2018
Bd. Ex. 21	Respondent's Board of Physicians Profile and Application/Renewal Materials, dated March 12, 2018

I did not admit any exhibits on behalf of the Respondent.

Testimony

The Board did not present any witnesses at the hearing.

The Respondent testified on his own behalf.

STIPULATED FACTS

1. At all times relevant to these charges, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice

[2] I have used initials throughout this decision in order to protect the privacy of the individuals involved in this case.

medicine in Maryland on February 18, 1987, under license number D34722. The Respondent's license is current through September 30, 2019.

2. The Respondent is also licensed to practice medicine in the District of Columbia.

3. The Respondent is board-certified in internal medicine.

4. The Respondent is a solo-practitioner operating in Bladensburg, Maryland.

5. In approximately April of 2015, the Respondent entered into an operating agreement with [redacted], owner of [redacted] (Facility). Pursuant to that agreement the Respondent became part-owner and medical director and would provide cosmetic injections and medical supervision of laser hair removal for technicians at the Facility.

6. From approximately April 2015 until August 2016, the Respondent was employed as the medical director at the Facility in North Bethesda, Maryland. The Facility offered services including medical and cosmetic injections, laser hair removal, facials, esthetics, and weight-loss management.

7. During the aforementioned time period, the Respondent supervised [redacted],[3] a technician, in the performance of laser hair removal and I-Lipo.[4]

8. From approximately 2013 through June 2016, [redacted] was employed at the Facility as a part-time medical esthetician. She was not licensed by the Board or the Maryland Board of Nursing. [redacted] was licensed by the Maryland Department of Labor, Licensing and Regulation as an esthetician. That license expired on or about July 17, 2017.

[3] The Board opened an investigation and charged [redacted] with the unauthorized practice of medicine under Board case # 2218-0108.

[4] I-Lipo is a dermatological aesthetic treatment for the shrinking of subcutaneous fat cells and reduction of bodily circumference that is achieved through the use of a laser light source.

9. On or about October 24, 2016, the Board received a complaint alleging that the Facility was allowing unlicensed individuals to practice medicine at the Facility. The Board initiated an investigation as a result of the complaint.

10. On or about August 17, 2017, the Board's staff conducted an unannounced site visit to the Facility. The Respondent was not present at the time of the visit. A technician was present in the laser room with a patient at the time of Board staff's arrival. After finishing up with the patient, the technician indicated to Board staff that she and another technician both perform laser hair removal and Intense Pulsed Light (IPL)[5] and escorted Board staff to the laser room. The Board's staff noticed the odor of burnt hair in the laser room in which the patient had just been treated.

11. On or about August 21, 2017, the Board issued an initial contact letter and a subpoena *duces tecum* for appointment logs and employee records to the Respondent.

12. On or about August 25, 2017, Board staff received the Respondent's written response to the initial contact letter. In his written response, the Respondent stated that he had been formerly employed by the Facility, and that he had supervised laser hair removal clients and technicians during his time there. The Respondent did not provide any materials responsive to the issued subpoenas as he indicated that he did not have access to the information.

13. On or about October 12, 2017, Board staff conducted an interview with the Respondent under oath regarding the aforementioned allegations. During the interview, the Respondent stated that he worked at the Facility from approximately April 2015 through July 2016.

[5] IPL uses the emission of broad spectrum light through intense pulses to improve the appearance of skin and for hair removal.

14. The Respondent indicated that during the course of his tenure at the Facility he acted as partial owner and medical director. The Respondent's duties included seeing laser patients and supervising the laser technician.

15. The Respondent acknowledged that during the period of his working at the Facility, [redacted] operated as the laser technician performing IPL and laser hair removal treatments. The Respondent further stated that [redacted] would operate under the Respondent's direction when treating patients. Most of the time, the Respondent would be present in the room during the treatments, but sometimes he would not.

16. The Respondent stated that his understanding was that the laser hair removal could be performed by the technician under his supervision.

17. On or about January 18, 2018, the Board's staff conducted an interview with [redacted], under oath regarding the allegations. During the course of this interview, [redacted] acknowledged that she regularly performed laser hair removal on patients under the supervision of the Respondent.

18. The Respondent, as part-owner/medical director of the Facility and supervisor of [redacted] oversaw [redacted]'s performance of laser hair removal procedures and was aware that [redacted] performed the procedures. The following represents a small sampling of women and men who received cosmetic medical treatments conducted by [redacted] under the supervision of the Respondent.

Patient 1:

- In approximately March of 2016, Patient 1, a female, was in her twenties when she presented to the Facility for cosmetic procedures including laser hair treatment.

- During Patient 1's initial visit on or about March 1, 2016, she signed a Laser Hair Removal Consent Form. The last paragraph of the Consent Form includes the following statement:

> I understand that the procedure is performed by a certified laser therapist, trained and supervised by [the Respondent] . . . [the Respondent] may not be physically overseeing your follow up treatments; however he will be available upon request[.]

- On or about March 1, 2016, and April 12, 2016, [redacted] performed laser hair removal on Patient 1's arms and underarm area.

Patient 2:

- On or about July 15, 2014, Patient 2, a female in her forties presented to the Facility for cosmetic procedures including laser hair treatment. During the course of her initial visit, Patient 2 signed the Laser Hair Removal Consent Form.

- On or about the dates of June 16, 2015, July 28, 2015, December 28, 2015, and February 9, 2016, [redacted] performed multiple sessions of laser hair removal on Patient 2's chin and upper lip.

Patient 3:

- On or about January 7, 2016, Patient 3, a female in her late teens, presented to the Facility for cosmetic procedures including laser hair treatment. During her initial visit, she signed the Laser Hair Removal Consent Form.

- On or about January 7, 2016, and March 18, 2016, [redacted] performed laser hair removal on Patient 3's bikini area.

Patient 4:

- On or about July 21, 2015, Patient 4, a female, presented to the Facility for cosmetic procedures including laser hair treatment. During her initial visit she signed the Laser Hair Removal Consent Form.

- On or about July 21, 2015, and February 26, 2016, [redacted] performed laser hair removal on the sides, underarm, and bikini areas of Patient 4.

Patient 5:

- On or about December 30, 2014, Patient 5, a female in her twenties presented to the Facility for cosmetic procedures including laser hair treatment. During her initial visit, she signed the Laser Hair Removal Consent Form.

- On or around the dates of June 5, 2015, July 10, 2015, August 22, 2015, October 3, 2015, and November 17, 2015, [redacted] performed laser hair removal on the chin, sides and neck area of Patient 5.

Patient 6:

- On or about June 20, 2015, Patient 6, a male in his twenties presented to the Facility for cosmetic procedures included laser hair treatment. Patient 6 signed the Laser Hair Removal Consent Form on the date of his initial visit.

- On or about the dates of December 5, 2015, February 6, 2016, and March 24, 2016, [redacted] performed laser hair removal on the lower back area of Patient 6.

PROPOSED FINDINGS OF FACT

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

1. At all times relevant to this proceeding, the Respondent was a licensed physician in the State of Maryland.

2. In 2011, the Respondent signed a lease for a cosmetic medical device capable of performing cosmetic medical procedures, including laser hair removal, IPL, and I-Lipo procedures.

3. Shortly before the Respondent entered into the operating agreement with [redacted], the Respondent transferred the device from his office to the Facility. He agreed that [redacted] may use the device if [redacted] paid the lease. He did not inform [redacted] or the Facility staff of any restrictions regarding the use of the cosmetic medical device.

4. During the period that the Respondent was the Facility's medical director, [redacted] was the Facility's administrator and office manager. [redacted] was not licensed to perform any cosmetic medical procedures. He sometimes performed medical procedures and led patients to believe that he was a medical professional.

5. The Respondent worked out of his office at the Facility two days per week, usually Tuesdays and Thursdays, and occasionally used the Facility office on other days if Botox appointments were scheduled.

6. The Respondent performed all Botox procedures at the Facility.

7. IPL, I-Lipo and laser hair removal are cosmetic medical procedures that only may be performed by licensed medical professionals.

8. None of the technicians or estheticians who worked at the Facility during the time when the Respondent was the Facility's medical director were licensed to perform cosmetic medical procedures.

9. Several of the Facility's technicians and estheticians received training on the medical device. The Respondent was present for the training.

10. At all times relevant to this matter, the Respondent conducted initial consultations with patients, sometimes by telephone or electronic media.

11. The Respondent determined the settings for each laser hair removal patient for the cosmetic medical device and noted the settings on the patient's chart.

12. The Facility's technicians and estheticians, including [redacted] routinely performed I-Lipo, IPL, and laser hair removal procedures on patients when the Respondent was not in the treatment room and when he was not at the Facility.

13. In July 2016, [redacted] a Facility medical esthetician, conducted evaluations and performed all services for laser hair removal procedures. The Respondent was not present but was available by telephone if any problems arose during the procedures.

14. On July 30, 2016, the Respondent signed a letter of intent indicating that he would sell his interest in the Facility to [redacted] for $1.00 as long as [redacted] satisfied certain requirements before October 30, 2016, including paying in full past due obligations for the leased cosmetic medical device and paying the remaining balance on a current note which funded the purchase of a second cosmetic medical device.

15. After August 1, 2016, the Respondent did not visit the Facility or see patients at the Facility.

16. [redacted] continued to schedule appointments for cosmetic medical procedures under the Respondent's name. Facility technicians and estheticians performed the procedures.

17. On August 13, 2016, the Respondent and [redacted] memorialized the terms from the Respondent's letter of intent in an agreement. Under the agreement, the Respondent would remain medical directer until October 31, 2016. (Bd. Ex. 14).

18. [redacted] paid $70,000.00 to the Respondent for the Respondent's loans pertaining to the medical devices. At the time of [redacted]'s interview with a Board compliance analyst, [redacted] still owed money to the Respondent for the medical devices, which remained at the Facility.

19. On December 9, 2016, [redacted], a former Facility employee, filed a complaint with the Board, reporting poor conditions at the Facility, including dirtiness, drug use by employees during business hours, and unlicensed staff performing I-Lipo and laser hair removal procedures.

She identified patients who had made complaints "that they are breaking out and/or have rashes after receiving treatment." (Bd. Ex. 3).

20. Sometime in April 2017, the Respondent informed [redacted] that he intended to resign as medical director at the facility.

21. In July 2017, [redacted], M.D., became medical director of the Facility.

22. On August 17, 2017, a compliance analyst from the Board conducted an unannounced site visit at the Facility. On that date, [redacted] a technician at the Facility, was performing laser hair removal procedures. The Respondent was not present. However, certificates and diplomas bearing the Respondent's name were displayed on the office wall.

DISCUSSION

Section 14-404 of the Medical Practice Act sets forth the grounds for which the Board may take disciplinary action against a licensed physician as follows:

> (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; or
> (ii) Unprofessional conduct in the practice of medicine[.]
>
> . . .
>
> (18) Practices medicine with an unauthorized person or aids an unauthorized person in the practice of medicine[.]

Md. Code Ann., Health Occ. § 14-404(a)(3), (18) (Supp. 2018). Section 14-101 of the Health Occupations Article defines "[p]ractice medicine" as "to engage, with or without compensation, in medical: (i) Diagnosis; (ii) Healing; (iii) Treatment; or (iv) Surgery." Md. Code Ann., Health

Occ. § 14-404(a)(3), (18) (2014). The following definitions have relevance to the issues in this case:

> (4) Cosmetic Medical Device.
> (a) "Cosmetic medical device" means a device that alters or damages living tissue.
> (b) "Cosmetic medical device" includes any of the following items, when the item is used for cosmetic purposes:
> (i) Laser;
> (ii) Device emitting light or intense pulsed light;
> (iii) Device emitting radio frequency, electric pulses, or sound waves; and
> (iv) Devices used for the injection or insertion of foreign or natural substances into the skin, fat, facial tissue, muscle, or bone.
>
> (5) Cosmetic Medical Procedure.
> (a) "Cosmetic medical procedure" means a procedure using a cosmetic medical device or medical product to improve an individual's appearance.
> (b) "Cosmetic medical procedure" includes the following:
> (i) Skin treatments using lasers;
> (ii) Skin treatments using intense pulsed light;
> (iii) Skin treatments using radio frequencies, microwave, or electric pulses;
> (iv) Chemical peels that ablate living skin tissue;
> (v) Skin treatments with phototherapy;
> (vi) Dermabrasion;
> (vii) Subcutaneous, intradermal, or intramuscular injections of medical products;
> (viii) Treatments intended to remove or cause destruction of fat; and
> (ix) Any treatment using a cosmetic medical device for the purpose of improving an individual's appearance.

COMAR 10.32.09.02B(4)-(5).

The Board argues that the Respondent is subject to a reprimand and a $20,000.00 fine based on his conduct as the medical director at the Facility. Specifically, it charges that the Respondent violated the above provisions by failing to properly supervise the medical procedures performed at the Facility. The Respondent argues that he was unaware that his actions violated the Medical Practice Act and that the circumstances do not warrant the proposed discipline in this case. Based on the evidence, I conclude the Respondent violated the above provisions of the Medical Practice Act by permitting unlicensed individuals to perform cosmetic

medical procedures using the Respondent's cosmetic medical device without supervision. For the reasons set forth below, I conclude the proposed discipline of a reprimand and a $20,000.00 fine is appropriate in this case.

The evidence established that the Respondent leased a cosmetic medical device capable of performing I-Lipo, IPL, and laser hair removal procedures for his own use in his solo practice. When he discovered that he could not profit from the device on his own, the Respondent offered the cosmetic medical device to [redacted] with the agreement that [redacted] reimburse the Respondent for the costs that the Respondent had incurred in leasing the device. At the time that he transferred the cosmetic medical device to the Facility, the Respondent did not place any restrictions on [redacted]'s use of the device. Shortly thereafter, the Respondent entered into the Operating Agreement and became part owner and medical director of the Facility whereby he was required to supervise cosmetic medical procedures performed at the Facility. Several technicians and estheticians provided statements in Board interviews confirming that the Respondent conducted initial consultations and determined the settings for the laser hair removal procedures, but that the unlicensed staff performed the cosmetic medical procedures, often when the Respondent was not at the Facility.

The Respondent did not contradict the evidence presented by the Board. He agreed that there were times when [redacted] performed laser hair removal procedures on patients when he was not in the room. He also stated that he suspected that [redacted] was using the cosmetic medical device when he was not at the Facility. Yet, the Respondent did not question [redacted] or employ any measures to ensure that the device was being used correctly in compliance with the regulations of the medical profession.

To the extent that the Respondent reported in his recorded interview that he told [redacted] that the device should not be used when he was not present, the statements provided by the

Facility staff contradict this claim. The technicians reported that the Facility's practice was for the Respondent to conduct the initial evaluation of the patient and instruct the technicians on the proper settings for the procedure, but that these initial meetings sometimes were conducted when the Respondent was not physically present at the Facility. The technicians further reported that the technicians and estheticians performed the laser hair removal procedures without the Respondent's presence or direct supervision. They stated the Respondent was available if there was a problem and that patients were informed that they could contact the Respondent if they had any questions or concerns. This information was set forth in the Laser Hair Removal Consent Forms signed by each patient prior to treatment. (Bd. Ex. 12).

I find the Respondent was aware that the Facility staff were using the cosmetic medical device in his absence. The evidence shows that the Respondent approved this Facility practice, which allowed him to treat patients at his solo practice and only be at the Facility two days per week. This evidence establishes that, upon transfer of the device to the Facility and during the period that the Respondent served as medical director, the Respondent did not monitor the use of the cosmetic medical device and did not supervise the cosmetic medical procedures performed by the Facility staff. Thus, the Respondent was aware that the medical device was being used by unlicensed individuals in and outside of his presence.

The Respondent's conduct violates section 14-404(a)(18) because the Respondent provided the cosmetic medical device to the Facility and knowingly permitted unauthorized individuals to perform cosmetic medical procedures, including I-Lipo, IPL, and laser hair removal. The Respondent's failure to monitor the use of the cosmetic medical device that he provided to the Facility permitted unlicensed and unauthorized individuals to practice medicine. This evidence also establishes a violation of Section 14-404(a)(3)(ii) which prohibits unprofessional conduct in the practice of medicine. Generally, unprofessional conduct is

"conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession." *Finucan v. Maryland Bd. of Physician Quality Assur.*, 380 Md. 577, 593 (2004), quoting *Shea v. Bd. of Medical Exam'rs*, 81 Cal. App.3d 564, 146 Cal. Rptr. 653, 660 (1978).

The evidence establishes that the Respondent did not monitor the Facility's use of the cosmetic medical device and did not supervise the medical procedures performed at the Facility or oversee the day-to-day activities at the Facility. As medical director, the Respondent was required to supervise cosmetic medical procedures such as I-Lipo, IPL, and laser hair removal and ensure that the medical procedures were performed by properly licensed individuals. The Respondent was present at the Facility only two days per week and provided limited supervision of the medical procedures performed at the Facility. Being available by telephone if a problem should arise is inconsistent with appropriate patient care, even when the individuals performing the medical procedures are licensed professionals. I conclude the Respondent's failure to monitor the Facility's use of the cosmetic medical device or to supervise medical procedures at the Facility constitutes unprofessional conduct in the practice of medicine.

Sanctions

In this case, the Board seeks to impose the disciplinary sanction of a reprimand and a fine of $20,000.00 based on the Respondent's violations. Md. Code Ann., Health Occ. § 14-404(a) (Supp. 2018); COMAR 10.32.02.09A; COMAR 10.32.02.10. Under the applicable law, the Board may impose a fine instead of or in addition to disciplinary sanctions against a licensee who is found to have violated section 14-404. Health Occ. § 14-405.1(a) (2014); COMAR 10.32.02.09C. In this case, the Board is seeking a fine of $20,000.00.

The matrix of sanctions found in COMAR 10.32.02.10 states that for violations of section 14-404(a)(3) that are not sexual in nature, the maximum sanction against a physician's license is

revocation and the minimum is a reprimand. The maximum fine is $50,000.00 and the minimum is $5,000.00. For violations of section 14-404(a)(18), the maximum sanction against the license is revocation and the minimum is a reprimand. The maximum fine is $50,000.00 and the minimum is $10,000.00. The Board's recommended sanctions fall within the guidelines.

I find that none of the aggravating or mitigating factors listed in COMAR 10.32.02.09B affect the outcome of this case, and there is no reason to depart from the sanctioning guidelines. The Respondent asks that I consider his lack of knowledge regarding the licensing requirements for professionals who are permitted to perform laser hair removal procedures, which he claims contributed to the violations in this case. I am not persuaded that this consideration has any effect on the outcome. The Respondent transferred the medical device to the Facility in exchange for compensation and assumed the supervisory role as medical director at the Facility in order to receive a benefit. He is presumed to know the statutes and regulations that apply to his profession. I also consider that the Respondent was actively involved in the decisions that contributed to the violations. He was not a victim of circumstance. Due to the Respondent's lack of attention, patients at the Facility were medically treated by unlicensed individuals. The potential for harm is immeasurable, and the Respondent was fortunate that no patient suffered great harm. The Board's recommendations are reasonable in light of the Respondent's actions, are supported by the factual evidence, and are well within the range of sanctions applicable to the violations.

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude as a matter of law that the Respondent committed unprofessional conduct in the practice of medicine. Md. Code Ann., Health Occ. § 14-404(a)(3)(ii) (Supp. 2018). I further conclude that the Respondent

practiced medicine with an unauthorized person and aided an unauthorized person in the practice of medicine. Md. Code Ann., Health Occ. § 14-404(a)(18) (Supp. 2018).

As a result of the Respondent's violations of the Medical Practice Act, I conclude that the Respondent is subject to disciplinary sanctions of a reprimand for the cited violation. *Id.*; COMAR 10.32.02.09A. I further conclude that the Respondent is subject to a fine of $20,000.00 for the cited violations. Md. Code Ann., Health Occ. § 14-405.1(a) (2014); COMAR 10.32.02.09C.

PROPOSED DISPOSITION

I **PROPOSE** that charges filed by the Maryland State Board of Physicians against the Respondent on February 28, 2018 be **UPHELD**; and

I **PROPOSE** that the Respondent be sanctioned by reprimand; and

I **PROPOSE** that the Respondent be ordered to pay a fine of $20,000.00.

June 26, 2019
Date Decision Issued

Michelle W. Cole
Michelle W. Cole
Administrative Law Judge

MWC/dlm
#180694

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

Michael Brown, Assistant Attorney General
Administrative Prosecutor
Health Occupations Prosecution and Litigation Division
Office of the Attorney General
300 West Preston Street, Room 201
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

Allen J. Kruger, Esquire
Kruger & Kruger, LLC
127 Lubrano Drive, Suite 300
Annapolis, MD 21401

Vicken Poochikian, MD
[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