IN THE MATTER OF	*	**BEFORE THE**
DAVID B. HARDING, M.D.,	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D35965	*	**Case Number: 2217-0089A**

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CONSENT ORDER

On June 28, 2019, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **DAVID B. HARDING, M.D.** (the "Respondent"), **License Number D35965**, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. §§ 14-101 *et seq.* (2014 Repl. Vol. & 2018 Supp.). Panel A charged the Respondent under the following provisions of the Act:

> **§ 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> (a) *In general.* – Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, 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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> . . .
>
> (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 11, 2019, Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of

the DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

Panel A finds:

I. BACKGROUND & LICENSING INFORMATION

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 initially licensed to practice medicine in Maryland on October 27, 1987, under License Number D35965. His license is active through September 30, 2020.

2. The Respondent is Board-certified in family medicine. At all times relevant to these charges, he practiced as a solo practitioner in Olney, Maryland.

3. In addition to his Maryland license, the Respondent holds active medical licenses in Ohio and Virginia. The Respondent holds inactive medical licenses in North Carolina and Pennsylvania.

II. COMPLAINT

4. On or about April 17, 2017, the Board received an anonymous complaint alleging that the Respondent refilled opioid prescriptions "even when patients' urine drug screens routinely come up negative" for prescribed opioids. The complaint alleged that the Respondent knew of at least one patient who gave his or her opioid prescription to someone else in the parking lot outside of the Respondent's office, yet the Respondent continued to prescribe opioids to that patient "as usual." The complaint also alleged that the Respondent allowed a "known opioid user" to volunteer at his practice.

III. BOARD INVESTIGATION

5. The Board initiated an investigation into the anonymous complaint.

6. As part of its investigation, the Board obtained a report from the Maryland Prescription Drug Monitoring Program ("PDMP") that listed prescriptions for controlled dangerous substances ("CDS") that the Respondent wrote between January 1, 2016, and May 10, 2017.

7. Based on the PDMP report, the Board identified ten patients who received prescriptions for CDS from the Respondent during the reviewed period and, on or about June 8, 2017, subpoenaed records for those ten patients from the Respondent. The Board also notified the Respondent of the anonymous complaint and requested his written response.

8. On or about June 20, 2017, the Respondent provided the Board with the subpoenaed patient records as well as his written response to the complaint.

9. In his written response, the Respondent stated that each urine drug screen result "is dealt with appropriately." He also stated that if he received information about his patients exchanging prescriptions, he would "evaluate it thoroughly and respond with appropriate actions." The Respondent explained that the patient who volunteered in his office was a medical assistant who wanted to refresh her skills. He wrote that her work was "entirely appropriate," and that he did not believe her recurrent opioid prescriptions would preclude her from volunteering in his office.

10. On or about August 30, 2017, Board staff interviewed the Respondent under oath. The Respondent stated that approximately five years earlier he completed a pain management program offered through the American Academy of Family Physicians.

He also explained his understanding of the treatment protocol for pain management patients around that time was to switch patients from short-acting to long-acting opioids by reducing oxycodone doses and starting patients on either methadone or fentanyl. He stated that "the NIH paper[[1]] basically . . . disavowed that," and the focus then became adjusting opioid doses based on morphine milligram equivalents ("MME").[2] The Respondent stated that as a result of using an MME-based dosing guideline, he now concentrates on lowering the methadone doses that he prescribes. The Respondent also stated that he has been unable to transition some patient care to pain medicine specialists because these specialists have told the Respondent that his patients are "on such a high dose," and that these specialists will take over patient care only if the Respondent lowers his patients' opioid doses.

A. PEER REVIEW

11. As part of its investigation, the Board referred the ten patient records obtained from the Respondent and related materials to a peer review entity for review.

12. Two peer reviewers, who were each Board-certified in anesthesiology with subspecialty certification in pain medicine, separately reviewed the ten patient records.

13. Each peer reviewer determined that in all ten of the reviewed records the Respondent was deficient in both his prescribing practices as well as his recordkeeping.

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[1] While the National Institutes of Health ("NIH") has published information about opioids, it is believed that the Respondent is referring to the *CDC Guideline for Prescribing for Chronic Pain* (the "CDC Guideline") issued by the Centers for Disease Control and Prevention ("CDC"), which was first published on or about March 18, 2016.

[2] MME is a value assigned to each opioid to represent its relative potency using morphine as the standard comparison. The CDC Guideline uses MME to establish recommended opioid dosing and currently recommends using precaution when prescribing opioids doses greater than or equal to 50 MME per day and avoiding or carefully justifying a decision to increase opioid doses greater than or equal to 90 MME per day.

B. PATIENT-SPECIFIC ALLEGATIONS

Patient 1[3]

14. At the time of review, Patient 1 was in his late-30s. His medical history included lower back pain and migraines. An orthopedic surgeon previously determined that Patient 1 was a candidate for spinal surgery, though he did not have it done. While not documented as having either high blood pressure or high cholesterol, the Respondent routinely prescribed Patient 1 medications to address both of these issues.

15. From October 2012 to June 2017, the Respondent maintained Patient 1 on high doses of methadone to manage his back pain. During this time, the Respondent prescribed Patient 1 methadone at doses ranging from 50mg to 100mg per day. These doses of methadone totaled 500 MME to 1,200 MME per day.

16. On or about February 19, 2015, Patient 1 complained of memory loss and requested that the Respondent reduce his methadone dosage. The Respondent reduced Patient 1's methadone dosage from 100mg per day to 60mg per day but did not document a plan for tapering the patient's doses or weaning him off opioids. In about three weeks, on or about March 9, 2015, the Respondent noted that Patient 1's "back hurts bad," and returned Patient 1 to 100mg of methadone per day. Other than Patient 1's complaints of pain, the Respondent did not document a comprehensive assessment or objective findings to justify his decisions.

17. On or about May 18, 2015, Patient 1 again requested that the Respondent gradually reduce his methadone dosage. The Respondent reduced Patient 1's methadone

[3] To maintain confidentiality, the names of all witnesses, facilities, employees, and patients will not be used in this document but will be provided to the Respondent on request.

dosage from 100mg per day to 60mg per day but did not document a plan for tapering the patient's dosages or weaning him off opioids. On or about June 11, 2015, the Respondent noted that Patient 1 had self-escalated his methadone dosage and was using 90mg per day. The Respondent took no action. On or about July 24, 2015, Patient 1 told the Respondent that he was still taking 90mg of methadone per day and "does better on 10 tablets" (equal to 100mg per day). The Respondent increased Patient 1's methadone prescription from 60mg per day to 100mg per day. Other than Patient 1's self-reported pain, the Respondent did not document a comprehensive assessment or objective findings to support or justify his decisions.

18. On or about August 6, 2015, the Respondent noted that Patient 1 took "a lot" of methadone and had presented with "overuse of pain med (doubled)."[4] The Respondent discontinued Patient 1's methadone for 36 hours and prescribed suboxone. After 36 hours, the Respondent prescribed Patient 1 methadone at 50mg per day.

19. On or about August 12, 2015, approximately six days after presenting with "overuse" of methadone, Patient 1 told the Respondent that he had self-escalated his methadone dose and was taking 70mg per day, instead of the prescribed 50mg per day. In response, the Respondent increased Patient 1's methadone dosage to 70mg per day. The Respondent did not document a comprehensive assessment or objective findings to support or justify his decision.

20. On or about September 22, 2015, Patient 1 reported to the Respondent that he "threw his back out last night." The Respondent noted a physical examination finding

[4] The exact amount of methadone Patient 1 took is unclear from the records. The Respondent had prescribed Patient 1 with 100mg of methadone per day as of August 6, 2015. The Respondent noted "doubled" in the patient's records, suggesting that Patient 1 took up to 200mg of methadone.

of "back sore," but did not document any abnormal objective findings. The Respondent increased Patient 1's methadone dosage to 80mg per day and maintained him at that level until September 2016.

21. On or about June 23, 2016, July 28, 2016, and August 18, 2016, the Respondent noted that Patient 1 was self-escalating his methadone dosage by using "a few extra methadone" and taking up to 90mg per day despite being prescribed 80mg per day. The Respondent noted "back pain," but took no action during these office visits in response to the patient's self-escalation. On or about September 9, 2016, the Respondent increased Patient 1's prescribed methadone dosage to 90mg per day. The Respondent noted the patient's complaint of back pain but did not document a comprehensive assessment or objective findings to support or justify his decision.

22. On or about April 24, 2017, the Respondent noted that Patient 1 had again self-escalated his methadone by taking 100mg per day despite being prescribed 90mg per day. The Respondent took no remedial action in response. On or about May 25, 2017, the Respondent increased Patient 1's prescribed methadone dosage to 100mg per day.

23. Patient 1's records show that, in addition to those instances described above (*see* ¶¶ 16-17, 19-21, *supra*), the Respondent documented the patient's general complaint of pain but repeatedly did not document any comprehensive physical assessments or other objective findings to support or justify his decisions to increase, change, or refill the patient's high-dose opioid prescriptions.

24. Patient 1's records showed that between October 2014 and June 2017, the Respondent never required that the patient obtain an updated magnetic resonance

imaging (MRI) scan of his lumbar spine but continued to prescribe high-dose opioids to Patient 1 for lower back pain.

25. Patient 1's records showed that the Respondent did not conduct periodic electrocardiograms (EKGs) of the patient to assess any cardiovascular changes that may occur during high-dose opiate therapy.

26. Patient 1's records did not include any documentation that the Respondent checked PDMP to determine whether Patient 1 was complying with his prescriptions.

27. Patient 1's records revealed that the Respondent did not require Patient 1 to sign an opioid/medication agreement.

28. A peer review determined that the Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records regarding Patient 1 for reasons including:

a. Failing to address or take remedial actions in response to the patient's repeated self-escalations of his opioid dosages by not educating the patient, not prescribing naloxone, not weaning the patient off narcotics, and/or not referring the patient to addiction or behavioral therapy;

b. Failing to document objective support and justifications for increasing the patient's opioid dosages and continuing high-dose opiate therapy;

c. Failing to require the patient to obtain updated imaging studies, such as an MRI, to support the continuation of high-dose opiate therapy;

d. Failing to conduct periodic EKGs to assess any cardiovascular changes;

e. Failing to document an individualized assessment of the risks and benefits of continuing high-dose opiate therapy;

f. Failing to check PDMP to ensure the patient's compliance; and

g. Failing to require the patient to sign an opioid/medication agreement.

Patient 2

29. At the time of review, Patient 2 was in his mid-60s. His medical history included lower back pain, knee pain, anxiety, and chronic obstructive pulmonary disease. An EKG performed in 2012 showed Patient 2 had a borderline prolonged QTc interval of 449 milliseconds. He also had a prior history of alcohol and illicit drug abuse.

30. On or about September 7, 2012, the Respondent prescribed Patient 2 with Percocet 10-325mg, five times daily, which totaled 75 MME per day. The Respondent's assessment of Patient 2 noted "knee pain [and] back pain" and included vital signs but did document any other objective findings.

31. On or about November 29, 2012, Patient 2 told the Respondent that he saw a pain medicine specialist who "dismissed him" and did not prescribe opioids "because [Patient 2] got 12 days of meds from [the] hospital." The Respondent started Patient 2 on a fentanyl patch at 25mcg per hour. The Respondent also prescribed Percocet 10-325mg, five times daily. These doses totaled 105 MME per day. The Respondent did not document a comprehensive assessment or objective findings to justify his decision.

32. On or about December 28, 2012, the Respondent noted that Patient 2 was "doing ok with back pain." Despite this, the Respondent increased Patient 2's fentanyl dosage to 50mcg per hour, and continued Percocet 10-325mg, five times daily. These doses totaled 195 MME per day. The Respondent did not document a comprehensive assessment or objective findings to justify his decision.

33. On or about February 22, 2013, the Respondent noted that Patient 2 saw a pain medicine specialist who "recommends increasing meds."[5] The Respondent increased the patient's Percocet 10-325mg to six times daily and continued him on the same fentanyl dosage at 50mcg per hour. These doses totaled 210 MME per day. The Respondent's assessment of Patient 2 noted his complaint of "low back pain with radiation to both legs" and that it was "getting worse," but did not document any other objective findings to support or justify his decision.

34. On or about April 16, 2013, a palliative care specialist recommended that Patient 2 be switched from fentanyl to methadone to avoid adverse interactions with certain antidepressants. The Respondent started Patient 2 on methadone at 30mg per day, and maintained his Percocet 10-325mg, at six times per day. These doses totaled 330 MME per day.

35. Within approximately seven weeks, by June 4, 2013, the Respondent had increased Patient 2's methadone dosage to 80mg per day and replaced Percocet with oxycodone at 80mg per day. These new doses totaled 1,080 MME per day. During this seven-week escalation period, Patient 2 complained that the methadone did not help his pain. Patient 2's wife also called the Respondent's office to report that Patient 2 was in "a lot of pain." Both times the Respondent agreed to increase Patient 2's prescribed methadone dosage noting "back pain," but not providing any comprehensive assessments or objective findings to support or justify his decision.

[5] It is unclear from this note whether the Respondent spoke with the pain medicine specialist to confirm the recommendation, or whether Patient 2 had simply reported to the Respondent, and the Respondent accepted, that the pain medicine specialist recommended increasing his pain medication.

36. On or about June 25, 2013, Patient 2 reported that he had increased his own methadone dosage to 120mg per day as well as oxycodone to 120mg per day, and "can function on this well." In response, the Respondent increased Patient 2's methadone dosage to 100mg per day and his oxycodone dosage to 100mg per day. These doses totaled 1,350 MME per day. The Respondent did not document a comprehensive assessment or any objective findings to support or justify his decision.

37. On or about December 6, 2013, the Respondent noted that Patient 2 was "doing ok on meds," but also that he was "still in a lot of pain." The Respondent increased Patient 2's oxycodone dosage to 120mg per day and maintained his methadone dosage at 100mg per day. These doses totaled 1,380 MME per day. Other than the patient's self-reported pain, the Respondent did not document a comprehensive assessment or other objective findings to support or justify his decision.

38. On or about April 25, 2014, Patient 2 stated that he needed a fentanyl patch because, in the patient's opinion, it helped him more than methadone. The Respondent agreed to prescribe fentanyl and started Patient 2 on a fentanyl patch, 25mcg per hour. The Respondent maintained Patient 2 on methadone at 100mg per day and oxycodone at 120mg per day. These medications included two long-acting opioids and totaled 1,440 MME per day. The Respondent's assessment noted "chronic pain," but did not document any objective findings to support or justify his decision.

39. On or about August 8, 2014, the Respondent noted that Patient 2 underwent surgery and had taken "extra meds" for his post-operative pain. The Respondent did not document the dosage that Patient 2 had taken. The Respondent prescribed a fentanyl

patch at 50mcg per hour and maintained the patient on his current levels of methadone and oxycodone. These doses totaled 1,500 MME per day.

40. On or about May 13, 2015, the Respondent noted that Patient 2 "ran out of oxycodone, used extra." The Respondent took no remedial action and did not document the dosage Patient 2 had taken to cause him to run out of oxycodone early. He increased the patient's fentanyl dosage to 100mcg per hour and maintained him on oxycodone at 120mg per day and methadone at 100mg per day. These doses totaled 1,620 MME per day. The Respondent noted "back pain," but did not document a comprehensive assessment or objective findings to justify his decision. The Respondent maintained Patient 2 on these dosages for approximately two years, until on or about May 31, 2017.

41. On or about November 28, 2016, Patient 2 was evaluated at a pain treatment center in Durham, North Carolina ("Pain Center 1"). The evaluating physician at Pain Center 1 reported that Patient 2 was "on extraordinarily high doses of opioids which [the evaluating physician] has seldom seen for non-cancer pain, and these are not even remotely close to guidelines set forth by the CDC for prescribing chronic opioids." The evaluating physician reported his belief that the treatment of Patient 2 with opioids at their current dosages was unsafe, and he doubted whether Patient 2 was a good candidate for chronic opioid therapy.

42. On or about March 27, 2017, Patient 2 was evaluated at a pain treatment center in Wilson, North Carolina ("Pain Center 2"). A report from the evaluating nurse practitioner noted her recommendation that Patient 2 "seek weaning assistance from high dose opioids via a Methadone clinic." In a letter to the Respondent dated April 7, 2017,

the evaluating nurse practitioner clarified that Pain Center 2 "does not prescribe the narcotics in [the] combination that your patient is currently prescribed."

43. On or about May 31, 2017, the Respondent noted that Patient 2 had a pressure ulcer, aspiration pneumonia, and was "not moving around much [because] of wounds" and therefore "doesn't need as much narcotics." The Respondent decreased the patient's opioid dosages by nearly half to methadone at 60mg per day, oxycodone at 60mg per day, and a fentanyl patch at 50mcg per hour. The Respondent did not document a plan for tapering Patient 2's dosages or weaning him off opioids.

44. Patient 2's records show that, in addition to those instances described above (*see* ¶¶ 31-33, 35-38, and 40, *supra*), the Respondent documented the patient's general complaint of pain but repeatedly did not document any comprehensive physical assessments or other objective findings to support or justify his decisions to increase, change, or refill the patient's high-dose opioid prescriptions.

45. Patient 2's records showed that the Respondent did not conduct periodic EKGs of the patient to assess any cardiovascular changes, including to his QTc interval, that may occur during high-dose opiate therapy.

46. Patient 2's records showed that the Respondent did not require Patient 2 to sign an opioid/medication agreement.

47. Patient 2's records showed that from September 2012 through June 2017, the Respondent checked PDMP only once, in June 2016.

48. Patient 2's records showed that the Respondent did not check for fentanyl in any urine drug screens despite continuously prescribing him fentanyl since April 2014.

49. A peer review determined that the Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records regarding Patient 2 for reasons including:

a. Failing to document objective support and justifications for increasing the patient's opioid dosages and continuing high-dose opioid therapy;

b. Failing to address or take remedial actions in response to the patient's self-escalations of his opioid dosages by not educating the patient, not prescribing naloxone, not weaning the patient off narcotics, and/or not referring the patient to addiction or behavioral therapy;

c. Prescribing two long-acting opioids at the same time;

d. Failing to include all prescribed opiates in urine drug screens;

e. Failing to wean the patient safely rather than rapidly reducing opioid prescription levels and putting patient at risk of withdrawal;

f. Failing to conduct periodic EKGs to assess any cardiovascular changes;

g. Failing to document an individualized assessment of the risks and benefits of continuing high-dose opiate therapy;

h. Failing to check PDMP routinely to ensure the patient's compliance; and

i. Failing to require the patient to sign an opioid/medication agreement.

Patient 3

50. At the time of review, Patient 3 was in his mid-40s. His medical history included chronic back pain after an accident in 2009 as well as anxiety.

51. On or about October 19, 2012, the Respondent noted that Patient 3 had "back pain [and] panic attacks," but did not provide any other comprehensive assessment or objective findings other than vital signs. The Respondent prescribed oxycodone, 150mg per day, which appears to have been a continuation of his existing dosage. This

dose totaled 225 MME per day. The Respondent maintained Patient 3 on this dosage until on or about February 17, 2014.

52. On or about February 17, 2014, the Respondent noted that Patient 3 had tested positive for buprenorphine at his last urine drug screen. Patient 3 explained that he had lost his medication and used a friend's Butrans® patch. In response, the Respondent reduced Patient 3's oxycodone to 120mg per day and noted that he would consider prescribing Butrans® or suboxone at a follow-up appointment in two weeks. Ten days later, on or about February 27, 2014, the Respondent increased Patient 3's oxycodone dosage back to 150mg per day.

53. On or about April 15, 2014, the Respondent noted that a search through the Chesapeake Regional Information System for our Patients ("CRISP") showed Patient 3 had received two pain medications from other physicians, but that "he denies this[.]" The Respondent prescribed Patient 3 Oxycontin Extended Release ("Oxycontin ER"), 40mg per day. He reduced Patient 3's oxycodone dosage to 120mg per day. These doses totaled 240 MME per day.

54. On or about June 6, 2014, the Respondent noted that Patient 3 "ran out" of both Oxycontin ER and oxycodone that had been prescribed on or about May 12, 2014. The Respondent did not take any remedial action or attempt to document the dosages Patient 3 took that caused him to run out of narcotics early. The Respondent increased Patient 3's dose of Oxycontin ER to 60mg per day and reduced his oxycodone to 90mg per day. The Respondent noted "back pain," but did not provide a comprehensive assessment or objective findings to justify his decision.

55. On or about July 14, 2014, Patient 3 reported that he had "flipped his car" the day before and his medications "were in the side holder" and could not be recovered. The Respondent did not document that he requested or received an accident report from the patient. The Respondent proceeded to issue Patient 3 prescriptions for Oxycontin ER and oxycodone.

56. On or about October 16, 2014, Patient 3 reported that his medications were stolen. Patient 3 told the Respondent that he reported it to the police, but the Respondent did not document that he ever received a copy of the police report before continuing to prescribe opioids. The Respondent prescribed Patient 3 a fentanyl patch, 50mcg per hour, and oxycodone at 120mg per day. These doses totaled 300 MME per day.

57. By February 3, 2015, the Respondent had maintained Patient 3's fentanyl patch dosage at 50mcg per hour and reduced his oxycodone dosage to 75mg per day. These doses totaled 232.5 MME per day. The Respondent maintained Patient 3 on these dosages through June 2017.

58. On or about April 18, 2015, the Respondent noted that Patient 3 needed an updated lower back MRI, and he would get one once "work slow[s] down." However, as of November 2, 2015, Patient 3 had not yet obtained an updated MRI; the Respondent again referred him for a lower back MRI. On or about May 22, 2016, Patient 3 told the Respondent that he recently obtained an updated lower back MRI from an imaging center in Westminster, Maryland. The Respondent called the imaging center to obtain a copy of the MRI results, but that imaging center said that Patient 3's most recent MRI was of his knee on May 5, 2014. Patient 3's records show that the Respondent did not follow-up on or take remedial action in response to Patient 3's false statement. The Respondent did

not receive an updated lower back MRI for Patient 3 through June 2017 but continued to prescribe him opioids for back pain.

59. Patient 3's records showed he had abnormal urine drug screens on or around February 5, 2014 (positive for buprenorphine), June 6, 2014 (negative for all prescribed medications), October 14, 2014 (positive for buprenorphine), and August 4, 2015 (positive for benzodiazepines). Following these abnormal drug screens, the Respondent either maintained Patient 3 at his current opioid dosages or slightly decreased some opioid dosages, only to resume higher dosages soon thereafter. The Respondent failed to order urine drug screens for the presence of fentanyl, despite having prescribed that medication to Patient 3 since October 2014.

60. Patient 3's records showed that from September 2012 through June 2017, the Respondent checked PDMP twice, in April 2014 and March 2015.

61. Patient 3's records showed that the Respondent did not require Patient 3 to sign an opioid/medication agreement.

62. A peer review determined that the Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records regarding Patient 3 for reasons including:

a. Failing to document objective support and justifications for increasing the patient's opioid dosages and continuing high-dose opiate therapy;

b. Failing to require the patient to obtain updated imaging studies, such as an MRI, to support the continuation of high-dose opiate therapy;

c. Prescribing opioids in dosages that were disproportionate to standard pain management requirements;

d. Failing to address aberrant behavior, including running out of medication early, stolen or lost medication, and abnormal drug screens,

by educating the patient, prescribing naloxone, weaning the patient off narcotics, and/or referring the patient to addiction or behavioral therapy;

e. Failing to include all prescribed opiates in urine drug screens;

f. Failing to document an individualized assessment of the risks and benefits of continuing high-dose opiate therapy;

g. Failing to check PDMP routinely to ensure the patient's compliance with his prescriptions; and

h. Failing to require the patient to sign an opioid/medication agreement.

Patient 4

63. At the time of review, Patient 4 was in his late 20s. His medical history included abdominal pain following removal of a ganglioneuroma as well as anxiety.

64. As of July 12, 2012, the Respondent maintained Patient 4 on methadone at 80mg per day and oxycodone at 150mg per day. The doses totaled 1,185 MME per day. In October 2012, the Respondent reduced Patient 3's oxycodone dosage to 100mg per day but kept his methadone dosage at 80mg per day.

65. On or about June 14, 2013, the Respondent noted that Patient 4 was doing more "physical work" for his business. The Respondent increased Patient 4's oxycodone dose to 120mg per day "when physically active," with an intent to "cut down later." The Respondent did not document that the patient had any new or increased pain and did not document a comprehensive assessment or objective findings to justify his decision.

66. On or about August 9, 2013, the Respondent noted that Patient 4 "has some sweating he thinks it is due to needing more methadone . . . ." The Respondent agreed to increase Patient 4's methadone dose to control his sweating. The Respondent prescribed methadone at 100mg per day and maintained oxycodone at 120mg per day. These doses totaled 1,380 MME per day.

67. On or about October 1, 2013, the Respondent noted that Patient 4 had been recently hospitalized for kidney stones and had been prescribed hydromorphone for the associated pain. The Respondent prescribed hydromorphone, as needed, up to 16mg per day. He maintained Patient 4 on methadone at 100mg per day and oxycodone at 120mg per day. These doses totaled up to 1,444 MME per day.

68. On or about April 4, 2014, the Respondent noted Patient 4 had "withdrawal symptoms," though his prescriptions had not changed. The Respondent also noted "abdominal pain" but did not document any objective findings other than vital signs. The Respondent prescribed hydrocodone-acetaminophen, 10-325mg tablet, six times daily.

69. On or about April 7, 2014, Patient 4 called the Respondent's office to report that had run out of oxycodone because of increased back pain. The Respondent did not take any remedial action to address the self-escalation or attempt to document the doses Patient 4 had taken. The Respondent prescribed hydromorphone, 16mg per day, over the phone.

70. On or about April 11, 2014, the Respondent noted that Patient 4 had run out of hydromorphone and methadone three days early. Patient 4 said he was using twice the prescribed dose of hydromorphone for his back pain. The Respondent started Patient 4 on a fentanyl patch at 50mcg per hour.

71. On or about April 16, 2014, the Respondent noted that Patient 4 continued to have severe back pain. The Respondent prescribed methadone at 100mg per day, oxycodone at 120mg per day, and fentanyl at 50mcg per hour. These doses totaled 1,500 MME per day. The Respondent noted Patient 4's self-reported abdominal and back pain but did not document any objective findings to justify his decision.

72. On or about May 8, 2014, the Respondent noted that Patient 4 had begun physical therapy. The Respondent increased the patient's fentanyl dose to 75mcg per hour and continued his oxycodone and methadone doses. The Respondent noted "abdominal pain [and] back pain" but did not document any objective findings to justify his decision.

73. On or about June 30, 2014, the Respondent noted that Patient 4 was waiting to see a pain medicine specialist. The Respondent increased the patient's oxycodone dosage to 150mg per day and continued his methadone dosage at 100mg per day and fentanyl dosage at 75mcg per hour. These doses totaled 1,605 MME per day. The Respondent noted the patient's self-reported pain but did not document any objective findings to justify his decision to increase and maintain the prescribed opioid dosages. The Respondent maintained Patient 4 on these opioid dosages for about 18 months.

74. Patient 4's records show that, in addition to those instances described above (*see* ¶¶ 65, 68, and 71-73, *supra*), the Respondent documented the patient's general complaint of pain but repeatedly did not document any comprehensive physical assessments or other objective findings to support or justify his decisions to increase, change, or refill the patient's high-dose opioid prescriptions.

75. Patient 4's records show he had abnormal urine drug screen on or around June 6, 2014 (negative for all prescribed medications). Patient 4's records do not show that the Respondent followed-up on this abnormal drug screen. In addition, no urine drug screens checked for the presence of fentanyl despite being prescribed since April 2014.

76. Patient 4's records show that the Respondent did not require Patient 4 to sign an opioid/medication agreement.

77. A peer review determined that the Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records regarding Patient 4 for reasons including:

a. Failing to document objective support and justification for increasing the patient's opioid doses and continuing him on high doses of opioids;

b. Failing to attempt a non-narcotic medication to treat patient's onset of back pain before prescribing hydromorphone;

c. Failing to address aberrant behavior, including self-escalation of opioid doses and an abnormal drug screen, by not educating the patient, not prescribing naloxone, not weaning the patient off narcotics, and/or not referring the patient to addiction or behavioral therapy;

d. Failing to include all prescribed opiates in urine drug screens;

e. Failing to document an individualized assessment of the risks and benefits of continuing high-dose opiate therapy; and

f. Failing to require the patient to sign an opioid/medication agreement.

Patient 5

78. At the time of review, Patient 5 was in her late 50s. Her medical history included chronic back pain, multiple back surgeries, and anxiety. She also had a history of being noncompliant with narcotic prescriptions. In 2004, a pain medicine specialist discharged her from his care for noncompliance with her treatment agreement and repeatedly losing her prescriptions. She was hospitalized in 2004, 2012, and 2013 for overdoses of prescribed medications.

79. As of about October 26, 2012, the Respondent was maintaining Patient 5 on methadone at 100mg per day, and oxycodone at 150mg per day. These medications totaled 1,425 MME per day. The Respondent maintained Patient 5 at these opioid dosages until on or about January 29, 2015.

80. On or about December 17, 2012, Patient 5's husband called the Respondent to notify him that Patient 5 was overusing her prescribed alprazolam. The Respondent prescribed clonazepam at 1mg per day. He later increased Patient 5's clonazepam dosage to 2mg per day and maintained that level through June 2017.

81. Patient 5's records showed that she underwent back surgery in January 2015. Her surgeon had prescribed Patient 5 Oxycontin ER for post-operative pain. On or about January 29, 2015, the Respondent prescribed Oxycontin ER at 120mg per day, maintained her on methadone at 100mg per day, and decreased her oxycodone to 90mg per day. These medications included two long-acting opioids and totaled 1,515 MME per day.

82. After five months, on or about May 26, 2015, the Respondent discontinued Oxycontin ER after Patient 5 complained that it did not work. The Respondent increased Patient 5's oxycodone dosage to 120mg per day and continued her methadone at 100mg per day. These doses totaled 1,380 MME per day. The Respondent maintained Patient 5 on these opioid dosages through June 2017.

83. On or about June 21, 2016, Patient 2's urine drug screen tested positive for cocaine. Patient 2 presented as "ill appearing," with "slurred speech, disheveled and sometimes incoherent." The Respondent noted an "unsteady gait." Nevertheless, the Respondent issued the patient's opioid prescriptions at the same dosages.

84. Patient 5's records showed that the Respondent documented the patient's complaints of pain but repeatedly did not document comprehensive physical assessments or other objective findings to support or justify his decision to increase, change, or reissue the patient's high-dose opioid prescriptions.

85. Patient 5's records showed she had abnormal urine drug screens on or about the following dates: June 21, 2016 (positive for cocaine), October 13, 2016 (positive for cocaine and alprazolam), February 14, 2017 (positive for cocaine), and March 16, 2017 (positive for diazepam). Patient 5's records showed that the Respondent did not follow-up on these abnormal drug screens or modify the patient's opioid prescriptions as a result.

86. Patient 5's records showed that the Respondent did not require Patient 5 to sign an opioid/medication agreement.

87. A peer review determined that the Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records regarding Patient 5 for reasons including:

a. Failing to address aberrant behavior, including abnormal drug screens, by not treating active addiction before continuing chronic pain treatment, not weaning the patient off narcotics, and/or not referring the patient to addiction or behavioral therapy;
b. Failing to document objective support and justification for increasing the patient's opioid dosages and continuing her on high doses of opioids;
c. Prescribing two long-acting opioids at the same time;
d. Failing to document an individualized assessment of the risks and benefits of continuing high-dose opiate therapy; and
e. Failing to require the patient to sign an opioid/medication agreement.

Patient 6

88. At the time of review, Patient 6 was in his late 50s. His medical history included chronic neck and back pain, multiple neck and back surgeries, and anxiety. In October 2014, a report from a pain medicine specialist who had been treating Patient 6 noted that the patient had a history of engaging in "diversionary behavior."

89. As of October 26, 2012, the Respondent had maintained Patient 6 on methadone at 100mg per day, oxycodone at 120mg per day, and clonazepam at 4mg per day. These doses totaled 1,380 MME per day.

90. On or about October 7, 2013, Patient 6 underwent back surgery. The following month, on or about November 26, 2013, the Respondent doubled Patient 6's oxycodone to 240mg per day and continued his methadone dosage at 100mg per day. These doses totaled 1,560 MME per day. The Respondent maintained the patient at these opioid dosages until on or about March 31, 2015.

91. On or about March 31, 2015, the Respondent noted that Patient 6 wanted to switch to Oxycontin ER, though neither the patient's reasoning nor any discussions were documented. The Respondent agreed and prescribed Oxycontin ER at 160mg per day and continued the patient on methadone at 100mg per day. The prescribed medications included two long-acting opioids and totaled 1,440 MME per day.

92. On or about May 26, 2015, the Respondent noted that Patient 6 wanted to switch back to oxycodone because the Oxycontin ER was not working. The Respondent prescribed oxycodone at 180mg per day and continued methadone at 100mg per day. The Respondent discontinued Oxycontin ER. These doses totaled 1,470 MME per day.

93. Patient 6's records show that the Respondent documented the patient's complaints of pain but repeatedly did not document comprehensive physical assessments or other objective findings to support or justify his decision to increase, change, or reissue the patient's high-dose opioid prescriptions.

94. Patient 6's records showed he had abnormal urine drug screens on or about the following dates: June 21, 2016 (positive for cocaine), July 19, 2016 (positive for alprazolam), October 13, 2016 (positive for alprazolam), and February 14, 2017 (positive for cocaine). Patient 6's records did not show that the Respondent followed-up on these abnormal drug screens or modified the patient's opioid prescriptions as a result.

95. Patient 6's records showed that the Respondent did not require Patient 6 to sign an opioid/medication agreement.

96. A peer review determined that the Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records regarding Patient 6 for reasons including:

a. Failing to address aberrant behavior, including abnormal drug screens, by not treating active addiction before continuing chronic pain treatment, not weaning the patient off narcotics, and/or not referring the patient to addiction or behavioral therapy;
b. Failing to document objective support and justification for increasing the patient's opioid doses and continuing him on high doses of opioids;
c. Prescribing two long-acting opioids at the same time;
d. Failing to document an individualized assessment of the patient's risks and benefits of continuing high-dose opiate therapy; and
e. Failing to require the patient to sign an opioid/medication agreement.

Patient 7

97. At the time of review, Patient 7 was in her early 50s. Her medical history included back spasms, carpel tunnel syndrome, anxiety, hypothyroidism and insomnia.

98. As of October 4, 2012, the Respondent maintained Patient 7 on tramadol[6] at 200mg per day and Xanax at 2mg per day, as well as Ambien and Adderall.

99. On or about March 18, 2013, Patient 7 called the Respondent's office and requested that she be prescribed Tylenol with Codeine #3 for her back pain. The Respondent prescribed Tylenol with Codeine #3 over the phone.

100. On or about October 3, 2013, Patient 7 called the Respondent's office and requested that she be prescribed Tylenol with Codeine #3 for menstrual cramps and back pain. The Respondent prescribed Tylenol with Codeine #3 over the phone.

101. Patient 7's records showed that the Respondent documented the patient's complaints of pain but routinely did not document comprehensive physical assessments or other objective findings to support or justify his decision to increase, change, or reissue the patient's opioid prescriptions.

102. Patient 7's records showed that the Respondent did not attempt to monitor the patient's compliance with medications through either routine PDMP checks or urine drug screens, especially after tramadol became a controlled substance in August 2014.

103. Patient 7's records showed that the Respondent did not require Patient 7 to sign an opioid/medication agreement.

104. A peer review determined that the Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records regarding Patient 7 for reasons including:

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[6] Effective August 18, 2014, the U.S. Drug Enforcement Agency listed tramadol as a Schedule IV narcotic under the federal Controlled Substances Act.

a. Failing to document objective findings and justifications for continuing to prescribe opioids;

b. Failing to ensure the patient's compliance with his opioid prescriptions by routinely checking PDMP or conducting random urine drug screens;

c. Failing to document an individualized assessment of the patient's risks and benefits of continuing chronic opiate therapy; and

d. Failing to require the patient to sign an opioid/medication agreement.

Patient 8

105. At the time of review, Patient 8 was in his late 50s. His medical history included anxiety, depression, attention deficit disorder, and hypertension.

106. On or about February 19, 2013, the Respondent noted that Patient 8 visited his office for a blood pressure check and bloodwork. The Respondent prescribed, among other things, tramadol "as needed for pain," at 200mg per day. The Respondent did not document any patient complaints of pain, a comprehensive assessment, or other objective findings during this visit.

107. On or about August 19, 2015, the Respondent noted that Patient 8 had hip pain, but a recent x-ray was normal. The Respondent found the patient had full range of motion with some tenderness in his hip. The Respondent prescribed a thirty-day supply of Tylenol with Codeine #3 with two available refills.

108. On or about October 5, 2016, Patient 8's wife called and requested a refill of the patient's tramadol prescription. The Respondent first directed the patient to come in to his office, but then refilled Patient 8's prescription for tramadol over the phone one week later without seeing Patient 8 in the office.

109. Patient 8's records showed that the Respondent documented the patient's complaints of pain but repeatedly did not document comprehensive physical assessments

or other objective findings to support or justify his decision to increase, change, or refill the patient's narcotic prescriptions.

110. Patient 8's records showed that the Respondent did not attempt to monitor the patient's compliance with medications through either routine PDMP checks or urine drug screens, especially after tramadol became a controlled substance in 2014.

111. Patient 8's records showed that the Respondent did not require Patient 8 to sign an opioid/medication agreement.

112. A peer review determined that the Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records regarding Patient 8 for reasons including:

a. Failing to attempt a non-narcotic medication to treat patient's onset of hip pain before prescribing an opioid;
b. Failing to document objective findings and justifications for continuing to prescribe opioids;
c. Prescribing an opioid by telephone without conducting an in-person assessment;
d. Failing to ensure the patient's compliance with his opioid prescriptions by routinely checking PDMP or conducting random urine drug screens;
e. Failing to document an individualized assessment of the patient's risks and benefits of continuing chronic opiate therapy; and
f. Failing to require the patient to sign an opioid/medication agreement.

Patient 9

113. At the time of review, Patient 9 was in his mid-40s. His medical history included paraplegia following a motorcycle accident, chronic back pain, chronic arm and leg pain, and recurrent sacral ulcers requiring wound care.

114. From December 2012 through June 2017, the Respondent maintained Patient 9 on oxycodone. During this time, Patient 9's oxycodone dosages ranged from 60mg to 150mg per day. In addition, the Respondent prescribed Patient 9 Percocet from August 2013 to April 2014, and Oxycontin ER from April 2014 through June 2017. During this time, Patient 9's Oxycontin ER dosage ranged from 60mg and 180mg per day. The Respondent's maximum combined opioid prescriptions for Patient 9 was in April 2015, when he prescribed oxycodone at 75mg per day and Oxycontin ER at 180mg per day. These doses totaled approximately 382.5 MME per day.

115. On or about June 11, 2013, Patient 9's urine drug screen was positive for cocaine. The Respondent did not document that he took any remedial action. At the patient's next office visit, on or about July 10, 2013, the Respondent increased Patient 9's oxycodone dosage from 120mg to 150mg per day and started Vicodin® 5-500mg, four times daily. The Respondent noted "chronic pain," but did not document a comprehensive assessment or other objective findings to justify his decision to increase Patient 9's opioid dosages, especially in light of his recent urine screen testing positive for cocaine.

116. On two occasions, the Respondent increased Patient 9's opioid dosages because the patient complained that cold weather was causing him more pain.

117. On two occasions, Patient 9 reported that his medications were stolen. The patient did not produce a police report either time. Both times the Respondent provided Patient 9 with two-to-three-weeks' worth of opioid prescriptions.

118. On two occasions, Patient 9 reported that he ran out of medications early. Both times the Respondent provided Patient 9 with his opioid prescriptions without any additional inquiry.

119. Patient 9's records showed that the Respondent documented only the patient's general complaints of pain but repeatedly did not document comprehensive physical assessments or other objective findings to support or justify his decision to increase, change, or reissue the patient's high-dose opioid prescriptions.

120. Patient 9's records showed that over a four-year period, he had abnormal urine drug screens eight times, on or around the following dates: June 11, 2013 (positive for marijuana, benzodiazepines, and cocaine); October 1, 2013 (positive for marijuana and buprenorphine, negative for prescribed oxycodone); June 25, 2014 (positive for marijuana and benzodiazepines, negative for prescribed oxycodone); January 30, 2015 (positive for marijuana, negative for prescribed oxycodone); October 27, 2015 (negative for all prescribed medications); March 22, 2017 (positive for marijuana, buprenorphine, methadone, and cocaine, negative for prescribed oxycodone); May 5, 2017 (positive for marijuana, methadone, and cocaine); June 2, 2017 (positive for marijuana, methadone, and buprenorphine). Patient 9's records showed that the Respondent failed to take any remedial action or modify the patient's opioid prescriptions as a result of these abnormal urine drug screens.

121. Patient 9's records showed that the Respondent did not monitor the patient's compliance with medications through routine random urine drug screens. There were multiple occasions where several months passed between urine drug screens. There were also multiple occasions when the Respondent asked that Patient 9 bring his own

catheter to provide a urine sample. On at least one occasion Patient 9 did not bring his own catheter, and no urine drug screen was conducted as a result.

122. Patient 9's records showed that the Respondent did not require Patient 9 to sign an opioid/medication agreement.

123. A peer review determined that the Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records regarding Patient 9 for reasons including:

a. Failing to document objective support and justification for continuing the patient on high doses of opioids;
b. Failing to address aberrant patient behavior, including his running out of medication early, stolen medication, and abnormal drug screens, by weaning the patient off narcotics and/or referring the patient to addiction or behavioral therapy;
c. Failing to require random urine drug screens, but instead forewarning the patient by asking him to bring his own catheter;
d. Prescribing two short-acting opioids simultaneously;
e. Failing to document an individualized assessment of the risks and benefits of continuing high-dose opiate therapy; and
f. Failing to require the patient to sign an opioid/medication agreement.

Patient 10

124. At the time of review, Patient 10 was in his mid-60s. His medical history included paraplegia following a motor vehicle accident and chronic back and neck pain.

125. From September 2012 through March 2017, the Respondent maintained Patient 10 on oxycodone ER and methadone, among other medications. These narcotics are both long-acting opioids. During this time, Patient 10's oxycodone ER dosage ranged from 150mg to 180mg per day, and his methadone dosage ranged from 100mg to 120mg

per day. The Respondent's maximum combined opioid prescription for Patient 10 began in July 2015 and continued through March 2017, when he prescribed oxycodone ER at 180mg per day and methadone at 100mg per day. These totaled 1,470 MME per day.

126. Patient 10's records showed that the Respondent repeatedly did not document comprehensive physical assessments or other objective findings to justify his decisions to increase, change, or reissue the patient's high dose opioid prescriptions.

127. Patient 10's records showed that over a four-year period, he had abnormal urine drug screens on or around the following dates: October 14, 2012 (positive for fentanyl); November 16, 2012 (positive for fentanyl); September 9, 2013 (positive for PCP); January 16, 2015 (negative for prescribed oxycodone); and June 24, 2016 (positive for cocaine). Patient 10's records showed that the Respondent failed to take any action or modify the patient's opioid prescriptions as a result of these abnormal urine drug screens.

128. Patient 10's records showed that the Respondent did not attempt to monitor the patient's compliance with medications through routine PDMP checks.

129. Patient 10's records showed that the Respondent did not require Patient 10 to sign an opioid/medication agreement.

130. A peer review determined that the Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records regarding Patient 10 for reasons including:

a. Failing to document objective support and justification for continuing the patient on high dosages of opioids;
b. Failing to address aberrant patient behavior, including abnormal drug screens, by weaning the patient off narcotics and/or referring the patient to addiction or behavioral therapy;
c. Failing to check PDMP routinely to ensure compliance;

d. Prescribing two long-acting opioids at the same time;

e. Failing to document an individualized assessment of the risks and benefits of continuing high-dose opiate therapy; and

f. Failing to require the patient to sign an opioid/medication agreement.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel A 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 care, in violation of Health Occ. § 14-404(a)(22) and that the Respondent 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 by Disciplinary Panel A of the Board, hereby:

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

ORDERED that the Respondent is permanently prohibited from prescribing and dispensing all Controlled Dangerous Substances (CDS)

ORDERED The prohibition on prescribing and dispensing goes into effect thirty (30) 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 or dispensed any CDS 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 within **SIX (6) MONTHS**, the Respondent is required to take and successfully complete a course in medical record keeping. 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 must provide documentation to the disciplinary panel that the Respondent has successfully completed the course;

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

(e) the Respondent is responsible for the cost of the course; and it is further

ORDERED that within three (3) years, the Respondent shall pay a civil fine of fifteen thousand ($15,000.00) dollars. The Payment shall be 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 the Respondent's license if the Respondent fails to timely pay the fine to the Board; 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 or her designee 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, 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 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).

09/27/2019
Date

Signature on File

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians

CONSENT

I, David B. Harding, 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 this right 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 my 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.

Signature on File

9/20/19
Date

David B. Harding, M.D.
Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Montgomery

I HEREBY CERTIFY that on this 20th day of September 2019, before me, a Notary Public of the foregoing State and City/County, personally appeared David B. Harding, 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.

Notary Public

My Commission expires: Dec. 1, 2019

STEPHANIE A. HASSE NOTARY PUBLIC MONTGOMERY COUNTY, MD MY COMMISSION EXPIRES 12-01-2019