IN THE MATTER OF	*	**BEFORE THE**
ABBIE L. FIELDS, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D41449	*	**Case Number: 2222-0146A**

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

CONSENT ORDER

On June 22, 2023, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **ABBIE L. FIELDS, M.D.** (the "Respondent"), License Number D41449, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2021 Repl. Vol. & 2022 Supp); Health Occ. §§ 15-101 *et seq.* (2021 Repl. Vol. & 2022 Supp.); and Md. Code Regs. ("COMAR") 10.32.03.01 *et seq.*

Panel A charged the Respondent with violating the following statutory and regulatory grounds:

Health Occ. § 14-404. Denials, reprimands, probations, suspension, 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:

(3) Is guilty of:

. . .

(ii) Unprofessional conduct in the practice of medicine; [and/or]

. . .

(43) Except for the licensure process described under Subtitle 3A of this title, violates any provision of this title, any rule or regulation adopted by the Board, or any State or federal law pertaining to the practice of medicine[.]

One form of unprofessional conduct in the practice of medicine is "disruptive behavior." "Disruptive physician behavior" has been addressed by both The Joint Commission[1] and the American Medical Association ("AMA").[2]

JOINT COMMISSION SENTINEL EVENT ALERT (2008)

On July 9, 2008, The Joint Commission issued a Sentinel Event alert entitled, "Behaviors that Undermine a Culture of Safety," which stated in pertinent part:

> Intimidating and disruptive behaviors can foster medical errors . . . contribute to poor patient satisfaction and to preventable adverse outcomes . . . increase the cost of care . . . and cause qualified clinicians, administrators and managers to seek new positions in more professional environments . . . Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.
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> Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions . . . Overt and passive behaviors undermine team effectiveness and can

[1] The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations), founded in 1951, is an independent, not-for-profit organization that accredits and certifies healthcare organizations and providers.

[2] The Board and the disciplinary panels may consider the Principles of Ethics of the American Medical Association, but those principles are not binding on the Board or the disciplinary panels. *See* COMAR 10.32.02.16.

compromise the safety of patients . . . All intimidating and disruptive behaviors are unprofessional and should not be tolerated.[3,4]

AMA OPINION 9.045 (JUNE 2000)

AMA Opinion 9.045, entitled, *Physicians with Disruptive Behavior*, adopted in June 2000, states in pertinent part:

...

(1) Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.) However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior.

AMA OPINION 9.4.4 (JUNE 2016)

AMA Code of Medical Ethics: Professional Self-Regulation Opinion 9.4.4, adopted in June 2016, entitled, *Physicians with Disruptive Behavior*, states in pertinent part:

The importance of respect among all health professionals as a means of ensuring good patient care is foundational to ethics. Physicians have a responsibility to address situations in which individual physicians behave disruptively, that is, speak or act in ways that may negatively affect patient care, including conduct that interferes with the individual's ability to work with other members of the health care team, or for others to work with the physician.

[3] In 2011, The Joint Commission revised the term "disruptive behavior" to "behavior or behaviors that undermine a culture of safety."

[4] In 2016, The Joint Commission noted that "while the term 'unprofessional behavior' is preferred instead of 'disruptive behavior,' the suggested actions in this alert remain relevant."

Under Health Occ. § 14-404(a)(43), the pertinent statutory and regulatory grounds include the following:

Health Occ. § 15-302. Delegation agreements.

(a) *In general.* – A physician may delegate medical acts to a physician assistant only after:

(1) A delegation agreement has been executed and filed with the Board; and

(2) Any advanced duties have been authorized as required under subsection (c) of this section.

(b) *Contents.* – The delegation agreement shall contain:

. . .

(5) An attestation that all medical acts to be delegated to the physician assistant are within the scope of practice of the primary or alternate supervising physician and appropriate to the physician assistant's education, training, and level of competence[.]

(c) *Prior approval.* -- (1) The Board may not require prior approval of a delegation agreement that includes advanced duties, if an advanced duty will be performed in a hospital or ambulatory surgical facility, provided that:

. . .

(iii) Each advanced duty to be delegated to the physician assistant is reviewed and approved within a process approved by the governing body of the health care facility before the physician assistant performs the advanced duties.

COMAR 10.32.03 Delegation of Duties by a Licensed Physician – Physician Assistant

.06 Delegation Agreements – Approval.

. . .

D. Advanced Duties in a Special Facility.

(1) Upon receipt of a delegation agreement at the Board of Physicians, a physician may delegate and a physician assistant may perform delegated core medical acts and advanced duties that have been approved through the special facility's privileging process.

.07 Supervising Physicians.

A. A primary supervising physician shall:

. . .

(4) Delegate only medical acts that:

(a) Are within the scope of practice of the primary supervision physician or an alternate supervising physician; and

(b) Are suitable to be performed by the physician assistant, taking into account the physician assistant's:

(i) Education;

(ii) Training; and

(iii) Level of competence;

(5) Obtain approval for the delegation of any advanced duties as specified in Regulation .06C, D, or E of this chapter[.]

On October 11, 2023, Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this

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

FINDINGS OF FACT

Panel A finds:

Background/Licensing Information

1. At all relevant times, the Respondent was and is a physician licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on March 18, 1991, under License Number D41449. The Respondent's Maryland medical license expires on September 30, 2024, subject to renewal.

2. The Respondent is board-certified in obstetrics and gynecology, and at all relevant times, practiced at a health care facility (the "Facility")[5] located in Maryland.

Mandated 10-Day Report

3. On or about March 30, 2022, the Board received a Mandated 10-Day Report (the "Report") from the Facility, which notified the Board that it terminated the Respondent's employment agreement, effective March 20, 2022. The Facility stated that it had placed the Respondent under a Focused Professional Performance Evaluation ("FPPE")[6] for "behavioral and communication issues when interacting with surgical

[5] For confidentiality and/or privacy reasons, the names of all healthcare facilities, physicians and associated staff will not be identified in this document.

[6] The Joint Commission defines a Focused Professional Performance Evaluation as a "process whereby the medical staff evaluates the privilege-specific competence of the practitioner that lacks documented evidence of competently performing the requested privileges(s) at the organization. This process may also

residents," and "rather than continue the FPPE [the Facility] terminated her employment agreement pursuant to the 90-day without cause provision."

Board investigation

4. After reviewing the above Report, the Board initiated an investigation of the Respondent's conduct at the Facility. As part of its investigation, the Board obtained documentary evidence that included the Respondent's written response to the Report and the quality assurance/risk management ("QA") file the Facility maintained on the Respondent. The Board also conducted under-oath interviews of the Respondent and current and former Facility practitioners/staff with knowledge of this matter.

Respondent's written response

5. By letter dated May 3, 2022, the Board notified the Respondent that it had received information that the Facility had terminated her employment rather than continue an FPPE for behavioral and communication issues when interacting with surgical residents. The Board informed the Respondent that it had opened an investigation into the matter and requested that she address the allegations in a written response.

6. By letter dated May 19, 2022, the Respondent responded to the allegations that were set forth in the Report. The Respondent denied engaging in disruptive behavior, asserting that instead, the Facility was "disinterested" in her "opinions and recommendations." The Respondent claimed that the Facility's reference in its Report to her FPPE for behavioral and communications issues was a "proverbial red herring" and

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be used when a question arises of a currently-privileged practitioner's ability to provide safe, high quality patient care."

that she "constructively interface[d] with residents." The Respondent acknowledged, however, that the teaching methods she followed have been "dramatically replaced" by "kinder/gentler teaching protocols" and claimed that her separation from the Facility was "mutual."

Board investigation findings

7. The Board's investigation revealed that the Respondent, who practiced at the Facility from in or around 2014 to in or around 2021, had a recurrent, documented history of engaging in unprofessional and disruptive behaviors toward surgical residents, staff and patients, which culminated in the Facility's decision to terminate her employment agreement in 2022.

8. The Facility first placed the Respondent under a "for cause" FPPE in 2015 after receiving a series of complaints about her disruptive behaviors. As part of this FPPE, the Facility required the Respondent to undergo counseling. The Facility then placed the Respondent under a second "for cause" FPPE in 2021, again for disruptive workplace conduct, subject to remediative conditions. Despite the Facility's efforts, however, the Respondent continued to engage in verbal outbursts and at times made rude, bullying, demoralizing or confrontational remarks to Facility residents and staff such that it interfered with the residents' ability to learn during their residencies. Other staff expressed fear of the Respondent and were either reluctant or unwilling to work with her or if they were assigned to assist her, refrained from addressing her out of fear.

9. During this time frame, the Facility received a series of complaints and negative performance reviews from residents about the Respondent's demeanor during

their rotations. The Respondent's conduct became so problematic that in mid-November 2021, the Facility discontinued her use of residents for surgical assistance.

10. The Board's investigation also determined that on November 18, 2021, the Respondent performed surgery with the assistance of a physician assistant whom the Facility had not credentialed for the advanced duties she performed during the surgery. This last event, coupled with other disruptive behaviors, caused the Facility to suspend the Respondent's clinical privileges. The Respondent started the case with a physician assistant as her surgical assistant since she could no longer use resident physicians at that time. During this case the Respondent experienced difficulty with the robotic equipment and waited outside the operating room for another physician to assist her in the case, causing the patient to remain anesthetized for an additional one and one-half hours.

11. The Facility determined that the Respondent's performance under the 2021 FPPE was unsatisfactory and suspended her operating room privileges from November 19, 2021, through December 17, 2021, after which it exercised its option to terminate the Respondent's employment agreement.

12. Examples of the Respondent's disruptive conduct include but are not limited to the following:

2015 FPPE

13. The Facility began receiving disruptive behavior complaints about the Respondent beginning in or around 2014. These complaints alleged, *inter alia*, that the Respondent exhibited "inappropriate/disruptive behavior with patients, residents, and

staff." As a result, the Facility ordered the Respondent to undergo a "for cause" FPPE, commencing on July 10, 2015. The Facility cited complaints including:

a. failing to return calls to a patient, leading the patient to lose confidence in the Respondent;

b. failing to do a proper scrub prior to gowning and gloving before a robotics procedure, during which she ignored a scrub tech's attempts to correct her;

c. making "remarks about personnel and competency";

d. inappropriate patient interactions; and

e. behaving in a "demeaning, intimidating and abusive" manner toward a resident and to other operating room staff.

14. During the FPPE, the Facility removed the Respondent from any unsupervised activity with residents or others in post-graduate learning settings. The FPPE also required the Respondent to undergo an evaluation with the Facility's Employee Health department and enroll in and successfully complete an approved counseling program. The Respondent reportedly completed the FPPE and its requirements, after which the Facility allowed her to resume unsupervised activities with residents.

Complaints from Facility staff

15. The Respondent's disruptive behaviors resulted in instances where Facility staff left their employment with the Facility. One example of this involved a nurse practitioner (the "NP") who resigned her position in November 2015 due to her inability to work with the Respondent. The NP reported to the Facility that the Respondent was disrespectful toward her and did not act in a collaborative manner. The NP stated that the Respondent would not discuss patient cases with her and ignored questions she had

regarding treatment planning for patients. The NP stated she witnessed the Respondent becoming very angry at times, not only with her but with other staff.

16. The NP stated that she believed the Respondent acted in an inappropriate manner with patients. For example, the Respondent showed impatience with, and would not answer, questions posed by inquisitive patients. The Facility also received complaints from a research nurse that the Respondent would become "very impatient" and "angry" when addressing demanding patients. The Facility also stated that a former Facility employee who had gone to the Respondent for treatment transferred her care to another health care facility due to the Respondent's interactions with her.

Complaints from research staff, 2017-2018

17. The Respondent's QA file also notes that a research group the Respondent was coordinating alleged that she engaged in disruptive behaviors toward them. The research group alleged that from in or around 2017 and continuing into 2018, the Respondent made belittling and ridiculing comments to group members, made dismissive, derogatory remarks, and questioned the research staff's competence on several occasions. Research group staff reported that the Respondent was at times abrasive, abrupt and made harassing remarks to them such that they intentionally limited their interactions with her. On two different occasions, the Respondent verbally threatened committee staff with harm. Examples included the Respondent making comments to staff such as, "I don't care if this place burns down!," "I want you guys to die!" and "Are you screwing with me? I will kill you!"

18. In a memorandum the committee issued that detailed its concerns, the research group staff stated, "On two different occasions, [the Respondent] has verbally threatened our staff harm to their person. This is unprofessional and intolerable behavior from not only an employee but a physician in current practice." The file also documents that the research team witnessed the Respondent being rude to patients involved in research trials and berating team members in front of patients. The Respondent's actions also caused at least one group member to leave employment with the Facility.

19. The Board interviewed three former members of the research group, who confirmed the examples of belittling and threatening language, making them afraid to be alone with the Respondent. One of the research team members stated that the committee compiled the memorandum because it "wanted to document interactions with [the Respondent] just showing how demeaning and how unprofessional and rude and . . . aggressive and threatening that she was to us as a research team." As a result of these concerns, Facility leadership imposed a requirement that the Respondent not be allowed to interact with the research team alone.

Complaint from Facility physician, 2018

20. On January 29, 2018, a Facility physician reported concerns to senior Facility leadership about the Respondent's behavior, including:

> (a) behavior in the operating room, where the Respondent exhibited impatience and stress, which impaired the residents' ability to learn. The physician noted that the residents felt "paralyzed" by the way the Respondent speaks to them, leading to diminished performance and difficulties in acquiring new knowledge/skills;

(b) concerns about retaliation, where the residents declined to put anything in writing or be identified by name due to fear of how the Respondent will react. After senior Facility representatives approached the Respondent to discuss these complaints, the Respondent reportedly admonished the residents who complained about her;

(c) confidentiality, where the Respondent disclosed confidential matters raised at a clinical competency committee meeting.

Incident occurring on February 25, 2021

21. The Respondent's QA file notes concerns about the Respondent's behavioral issues in 2021. On February 25, 2021, for example, the Respondent was scheduled to perform a surgical procedure. The procedure had to be delayed for approximately 20 minutes due to the temporary unavailability of medical equipment (sterilized trays) for the procedure. When this delay occurred, a nurse approached the Respondent and explained the reason for the delay. At first, the Respondent expressed an understanding for the delay. However, at or near the time the Respondent started performing the procedure, the Respondent began complaining about the delay in the delivery of the equipment and insisted that the nurse again explain the reason for the delay. The Respondent started yelling at the nurse, shouting at one point, "How come? What do these people upstairs do? They don't do their job, they're just there smoking and having sex."

22. The Board interviewed a Facility nurse who witnessed the Respondent's outburst, and stated that she was so shocked and intimidated by the Respondent's remarks that she refrained from speaking to the Respondent during the remainder of the procedure. The nurse further stated that on other occasions, the Respondent acted in an abusive manner

toward her, which included bullying her, yelling at her, at times talking to her in the third person and at times giving her the "silent treatment" when she asked questions.

2021 FPPE

23. On or about June 15, 2021, the Facility placed the Respondent on a "for cause" FPPE, citing the Respondent for "an escalating pattern of inappropriate and unprofessional behavior." The Facility required the Respondent to undergo remediation that included completing modules on the following topics: managing stress; providing effective feedback; workplace differences; and conflict resolution skills in the workplace. The Facility ordered that the FPPE remain in effect until on or about December 17, 2021.

2021 Letter of Agreement

24. On June 24, 2021, the Respondent entered into a Letter of Agreement ("LOA") with the Facility, which set forth the contract terms for her employment at the Facility. The LOA documented the Respondent's responsibilities under her new contract, including the requirement that she abide by the Facility's Expected Standards of Conduct policy.[7]

25. The Facility added the following specific language to the LOA based on its concerns about the Respondent's ongoing behavioral issues:

> Due to previous concerns related to specific behaviors you have exhibited that are in violation of such policies, if your behavior toward patients, their families, other physicians, and/or other staff does not comport with the [Facility's] standards and policies, as determined by

[7] Among other obligations, the Facility's professional standards policy required that at all times, the Respondent "act in an ethical manner; treat patients and their families, physicians and other members of the [Facility's] staff with respect and compassion at all times; and work in close harmony with other clinical and administrative personnel of the [Facility]."

> the President of the [Facility], in his sole and absolute discretion, in addition to any other right the [Facility] may have under the Standard Terms, the [Facility] may terminate your service as Division Director effective immediately upon giving you notice.

Disruptive behavior toward residents, 2021

26. Despite the Facility's interventions and warnings, the Respondent continued to engage in disruptive behaviors that affected the performance of the healthcare team. On the evening of November 4, 2021, two residents met with senior supervisory Facility physicians ("Physician-1" and "Physician-2," respectively) to express their concerns about the Respondent's disruptive behavior, which the residents observed while they assisted her during surgeries she performed on November 3 and 4, 2021.

27. The residents reported that during the course of these surgeries, the Respondent was "more irate than usual, condescending, impatient, and yelling in the OR setting." One of the residents reported that the Respondent made comments such as "incompetent," "I am over this month" and "I am over this team." The resident stated that the Respondent "frequently makes negative comments and contributes to a stressful working environment." The resident stated that the Respondent ridiculed her in front of other Facility staff, asked a scrub tech why she was listening to the resident, and at one point yelled at the resident, "Do you want this case? Do you want my job?" The resident attempted to diffuse the situation and reassure the Respondent that she did not want her job. The resident stated that the Respondent left the operating room twice for one-to-two-minute time periods on these dates in attempts to control her anger. The resident also stated that the Respondent made comments during a procedure that no one can perform the

particular procedure, even though the Respondent would not show them how or attempt to assist them. The residents stated that the Respondent's behavior contributed to a "negative learning environment." The residents further stated that the Respondent suggested that they were going to go "cry to" or were "going to tell" Physician-2 about her behavior. The residents stated that the Respondent's behavior was so intimidating that "you do not learn anything except how to minimize making her even more angry." One of the residents questioned the Respondent as to why she had excluded her from rounding with the team, to which the Respondent stated that she "needed a break" from the residents. Both residents stated that they were worried that the Respondent would retaliate against them.

28. Physician-2 received a text from a Facility attending physician on November 4, 2021, who stated that he observed one of the above residents upset and crying shortly after the Respondent's comments to her. The attending stated that the resident's emotional reaction was due to "more abuse from [the Respondent]."

29. After meeting with the residents on November 4, 2021, Physician-2 issued a memorandum, concluding that the Respondent "does not make a concerted effort to improve her skills . . . she seems to display little patience and continues to demonstrate a stressful and unprofessional learning environment for the residents. [The Respondent] and the residency would both benefit from a separation."

30. The Board interviewed the residents regarding their experience and confirmed that the Respondent made disparaging and belittling comments to them that interfered with their learning experience, and that they both feared retaliation from the Respondent if they reported her actions to Facility authorities.

31. Physician-1 and another senior Facility physician ("Physician-3") met with the Respondent on November 9, 2021, to discuss her disruptive behaviors. The physicians informed the Respondent that her actions toward the residents were unjustified and not to be "condone[d]," and that because of the Facility's concerns about the Respondent's disruptive behaviors, the Facility would no longer permit resident physicians to assist her in her surgical cases.

Respondent's use of non-credentialed staff, November 18, 2021

32. On November 18, 2021, the Respondent performed a robotically-assisted surgery on a patient without credentialed assistance. On this date, the Respondent performed the surgery without the assistance of residents after the Facility limited her use of residents due to her disruptive behaviors. Instead, the Respondent used two physician assistants during the procedure.

33. Prior to commencing the surgery, a Facility staff person observed that the Respondent was using physician assistants and informed her that they were not credentialed to assist her. Despite this warning, the Respondent went ahead with the surgery.

34. During the procedure, the Respondent noted a problem with the robotic equipment. One of the physician assistants (the "PA") assisted the Respondent in operating the robotically-assisted equipment used during the procedure. The Facility had not credentialed the PA to assist the Respondent to perform the advanced duties she performed, however. The PA was unsuccessful in operating the equipment, after which the Respondent contacted another physician, who was then at another health care facility

performing a procedure. The Respondent then waited outside the operating room for the arrival of the physician, which resulted in the patient remaining under general anesthesia for an additional one and one-half hours.

35. During the time the Respondent was sitting outside the operating room, the Facility staff person referred to above observed the Respondent and expressed concern to her about the Respondent's wellbeing. The Respondent replied to her in a dismissive manner.

36. The PA had a pre-existing Delegation Agreement with the Respondent, who was designated as the physician assistant's primary supervising physician. The Delegation Agreement, which was dated April 15, 2015, allowed the PA to conduct histories and physical examinations, interpret and evaluate patient data, first/second assist in surgery, initiate requests for lab studies, and write medical orders for [Facility] and issue prescriptions. The Respondent and the PA did not have a Delegation Agreement Addendum for Advanced Duties on file with the Board.

37. The Respondent permitted the PA to assist her with the robotically-assisted surgery, even though the Facility had not credentialed the PA to perform the specific advanced duties the PA was performing. The Respondent's failure to have credentialed practitioners present caused a delay in completing the surgery, during which time the patient was kept under general anesthesia for an additional one and one-half hour time period. The Respondent inappropriately delegated to the PA an advanced duty, even though the Facility had not credentialed or approved her to perform.

38. The Board interviewed the PA, who acknowledged that she did not have sufficient training in operating the robotic equipment and that the Facility had not trained or credentialed her to perform this advanced duty. The PA acknowledged that she had a limited amount of experience in robotics cases and the Respondent was aware of her level of training. She stated at some point there was difficulty retrieving a needle from the assistant port and the Respondent stepped out of the room to call a surgeon to assist her. She stated the Respondent communicated to the team that it "would be some time until [the other physician] came, and then she mentioned she'd be outside [the operating room] . . . she communicated once." The PA stated that the scrub tech and circulating nurse were upset that the Respondent did not wait in the operating room with them. The PA further stated that at some point she went out of the OR to "double check with the Respondent what the timeframe was and what was going on . . .."

39. In an interview with Board staff, Physician-1 stated that physician assistants were not trained to be surgical assistants on robotic cases. Physician-1 further stated that two days before the surgery (November 16, 2021), the PA reached out to her asking for robotics training.

40. The Respondent inappropriately delegated advanced duties to the PA, which the PA was not authorized/credentialed to perform and was inappropriate in view of the PA's level of experience, training and competence.

Reviews from residents

41. During this same time period, the Facility received several unsatisfactory reviews from some residents and operating room staff regarding the Respondent's

behavior. Some of the reviews cited the Respondent for disruptive and disrespectful behaviors that affected their ability to learn from the residency experience. The residents noted that at times, the Respondent was "tyrannical," "impatient," "disrespectful," "belittling," "throws tantrums," and will "yell profanities at you if displeased . . . she is very condescending most of the time and talks to us like we are small children."

42. After this surgery, Physician-1 called the Respondent into a meeting to discuss concerns relating to the November 18, 2021, surgery and her mounting behavioral issues. During the meeting, Physician-1 reminded the Respondent that her decision to conduct the surgery without a credentialed surgical assistant could increase harm to the patient and result in a delay.

Respondent's suspension, 2021

43. After this meeting, the Facility, through a letter dated November 19, 2021, notified the Respondent that it had suspended her operating room privileges, effective November 19, 2021, to December 17, 2021, based on continued "unprofessional conduct that has resulted in a hostile learning environment for residents."

44. By letter dated December 30, 2021, the Facility notified the Respondent that it was exercising its right to terminate the June 24, 2021, LOA, without cause. The Facility notified the Respondent that as of December 20, 2021, she would not provide any further medical services and that effective March 20, 2022, her medical staff privileges would be rescinded.

45. On or about January 5, 2022, the Respondent resigned her medical staff privileges at the Facility.

Interviews of Senior Facility practitioners

46. As part of its investigation, the Board conducted a series of under-oath interviews of senior supervisory Facility physicians and other Facility staff persons regarding the Respondent's behavioral issues. One supervisory staff person stated, "She is quick . . . to be very caustic when she thought things weren't going well and would say pretty demeaning things to people when she felt that they were . . . incompetent, which is one of the words that she would use a lot in regards to . . . what she thought they were doing and what they couldn't do. She wasn't one to apologize when things were brought to her attention. And I literally had people who would want to refuse to go into the room with her to do surgeries with her. . . Her tone would be very demanding, very sarcastic, demeaning. . . anything that may not have gone right, or there were issues, it was everyone else's fault. And she would sometimes target people, speak to them harshly, say things that were demeaning. Even when called out about it, she would either smirk about it or say it was true, but she would never apologize." The staff person added that to her knowledge, at least five staff persons requested not to work with the Respondent because of her behavioral issues.

47. The Board interviewed Physician 1, who currently maintains a leadership position at the Facility. Physician-1 stated that the Respondent was placed on an FPPE in June 2021 due to ongoing concerns from residents at multiple levels regarding "ongoing unprofessional behavior creating a very tense and . . . hostile environment within the O.R. itself." Physician-1 stated that she counseled the Respondent on more than one occasion about disruptive behaviors toward residents and suspended her from using residents after

the November 3-4, 2021, incident referred to above. Physician-1 stated that after the November 18, 2021, incident in which the Respondent used uncredentialed staff to assist her in a surgery, she suspended the Respondent for patient safety issues. Physician-1 stated that she disagreed with the Respondent's teaching approach, which included intimidation, devaluation and not treating residents with respect.

48. The Board interviewed Physician-2, who currently maintains a leadership position at the Facility. Physician-2 stated that she believed that the Respondent's mode of instruction was not professional. She stated that she encountered the two residents who assisted the Respondent on November 3-4, 2021, and that they were both emotionally affected by the experience.

49. The Board interviewed a physician who formerly maintained a leadership position at the Facility ("Physician-4"). Physician-4 stated that she received complaints from residents and nursing staff that the Respondent had engaged in intimidating, demeaning and disruptive behaviors, and on several occasions counseled her about her actions. Physician-4 stated that she believed that the Respondent's teaching style was not professional. Physician-4 stated that she placed the Respondent on a "for cause" FPPE for disruptive behaviors and provided counseling for the Respondent due to safety concerns.

Interview of the Respondent

50. The Board conducted an under-oath interview of the Respondent. The Respondent acknowledged that she was not "touchy-feely" or "necessarily full of love and kindness." The Respondent stated that for some of the residents from certain educational backgrounds, it was sometimes very hard to "educate [the residents] in a very calm

fashion." With respect to negative reviews some residents gave her, the Respondent acknowledged that she used "harsh demanding language," but asserted that she did not physically abuse the residents and never "threw things" at them. The Respondent admitted that the negative reviews the residents gave her caused the Facility to place additional language in the LOA to address her behaviors. The Respondent also acknowledged "yelling" at a resident on November 3-4, 2021, and that when she did so, she "technically" violated her 2021 FPPE. The Respondent further acknowledged that some of the residents she was instructing could "feel [her] anger" and that she does "know that residents get intimidated and afraid of [her]." With respect to her remark on February 25, 2021, to staff that some Facility staff were "smoking and having sex," the Respondent admitted making the statement, which she said was "probably a poor choice of words" and "sarcastic." The Respondent denied using profanity toward residents and staff but did acknowledge that her "voice escalated in tenor." With respect to the 2015 "for cause" FPPE, the Respondent acknowledged seeing a counselor, who provided counseling to her for intimidating behavior.

CONCLUSIONS OF LAW

Based on the Findings of Fact, Disciplinary Panel A of the Board concludes as a matter of law that the Respondent violated Health Occ. § 14-404(a)(3) - Is guilty of: (ii) Unprofessional conduct in the practice of medicine; Health Occ. § 14-404(a)(43) - Except for the licensure process described under Subtitle 3A of this title, violates any provision of this title, any rule or regulation adopted by the Board, or any State or federal law pertaining

to the practice of medicine. Under Health Occ.§ 14-404(a)(43), the pertinent statutory and regulatory grounds include Health Occ. § 15-302 and COMAR 10.32.03.01 *et seq.*

ORDER

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

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

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of **ONE (1) YEAR**[8] from the effective date of this Consent Order. During probation, the Respondent shall comply with the following terms and conditions of probation:

(1) The Respondent shall enroll in the Maryland Professional Rehabilitation Program ("MPRP") as follows:

> (a) Within 5 business days from the effective date of this Consent Order, the Respondent shall contact MPRP to schedule an initial consultation for enrollment;
>
> (b) Within 15 business days from the effective date of this Consent Order, the Respondent shall enter into a Participant Rehabilitation Agreement and Participant Rehabilitation Plan with MPRP;
>
> (c) The Respondent shall fully and timely cooperate and comply with all MPRP's referrals, rules, and requirements, including, but not limited to, the terms and conditions of the Participant Rehabilitation Agreement(s) and Participant Rehabilitation Plan(s) entered with MPRP, and shall fully participate and comply with all therapy, treatment, evaluations, and screenings as directed by MPRP;
>
> (d) The Respondent shall sign and update the written release/consent forms requested by the Board and MPRP, including release/consent forms to authorize MPRP to make verbal and written disclosures to the Board and to authorize the Board to disclose relevant information from

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

MPRP records and files in a public order. The Respondent shall not withdraw the release/consent;

(e) The Respondent shall also sign any written release/consent forms to authorize MPRP to exchange with (i.e., disclose to and receive from) outside entities (including all of the Respondent's current therapists and treatment providers) verbal and written information concerning the Respondent and to ensure that MPRP is authorized to receive the medical records of the Respondent, including, but not limited to, mental health and drug or alcohol evaluation and treatment records. The Respondent shall not withdraw the release/consent;

(f) The Respondent's failure to comply with any of the above terms or conditions including terms or conditions of the Participant Rehabilitation Agreement(s) or Participant Rehabilitation Plan(s) constitutes a violation of this Consent Order.

(2) Within **six (6) months** from the effective date of this Consent Order, the Respondent shall enroll in and successfully complete a Board-approved course in appropriate professional behavior and/or communication in the workplace. 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 Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the course;
(c) the course may not be used to fulfill the continuing medical education credits required for license renewal;
(d) the Respondent is responsible for the cost of the course.

(3) Within **ONE (1) YEAR** from the effective date of this Consent Order, the Respondent shall pay a civil fine of **FIVE THOUSAND DOLLARS ($5,000.00).** 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 Respondent shall not apply for early termination of probation; and it is further

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

ORDERED that after the Respondent has complied with all terms and conditions of probation and the minimum period of probation imposed by the Consent Order has passed, the Respondent may submit a written petition for termination of probation. After consideration of the petition, the Respondent's probation may be terminated through an order of the disciplinary panel. The Respondent may be required to appear before the disciplinary panel to discuss her petition for termination. The disciplinary panel may grant the petition to terminate the probation, through an order of the disciplinary panel, if the Respondent has complied with all the probationary terms and conditions and there are no pending complaints relating to the charges; and it is further

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

ORDERED that after the appropriate hearing, if the disciplinary panel determines that the Respondent has failed to comply with any term or condition imposed by this Consent Order, the disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice medicine in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on the Respondent, and

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

ORDERED that the effective date of the Consent Order is the date the Consent Order is signed by the Executive Director of the Board or her designee. The Executive Director 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 this Consent Order is a public document. *See* Md. Code Ann., Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6).

11/03/2023
Date

Signature On File

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians

CONSENT

I, Abbie L. Fields, 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.

11-2-2023
Date

Signature On File
Abbie L. Fields, M.D.
Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Montgomery

I HEREBY CERTIFY that on this 02 day of Nov 2023, before me, a Notary Public of the foregoing State and City/County, Abbie L. Fields, M.D., personally appeared and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSTH my hand and notarial seal.

NOTARY PUBLIC MONTGOMERY CO.

Notary Public

Nhan C. Tran
Notary Public
Montgomery County, MD
My Commission Expires: March 08, 2026

My commission expires: _____