

IN THE MATTER OF

*** BEFORE THE**

ANTHONY R. JOSEPH, M.D.

*** MARYLAND STATE**

Respondent

*** BOARD OF PHYSICIANS**

License Number: D47529

*** Case Number: 2219-0151 A**

**ORDER FOR SUMMARY SUSPENSION OF LICENSE
TO PRACTICE MEDICINE**

Disciplinary Panel A (“Panel A”) of the Maryland State Board of Physicians (the “Board”) hereby **SUMMARILY SUSPENDS** the license of **Anthony R. Joseph, M.D.** (the “Respondent”), License Number D47529, to practice medicine in the State of Maryland. Panel A takes such action pursuant to its authority under Md. Code Ann., State Gov’t § 10-226(c)(2) (2014 Repl. Vol. & 2019 Supp.), concluding that the public health, safety or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS¹

Panel A concludes that the Respondent’s continued practice of medicine poses a substantial likelihood or risk of serious harm to public health safety and welfare based on peer review findings that the Respondent’s practice of medicine “does pose a potential danger to his patients.”

¹ The statements about the Respondent’s conduct set forth in this document are intended to provide the Respondent with reasonable notice of the basis for this suspension. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this action.

I. BACKGROUND

1. At all relevant times, the Respondent was and is licensed to practice medicine in the State of Maryland. The Board initially issued the Respondent a license to practice medicine in Maryland on June 14, 1995, under License Number D47529. His license is active through September 30, 2020.

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

3. Since 2004, the Respondent has owned and operated a medical practice, “Anthony R. Joseph, M.D., LLC,” with an office in Baltimore, Maryland. The Respondent’s practice focuses on internal medicine and substance abuse treatment.

II. COMPLAINT

4. The Board initiated an investigation of the Respondent after reviewing a complaint (the “Complaint”) dated November 12, 2018 from a former patient of the Respondent (the “Complainant”)² who alleged that the Respondent would not treat her low potassium levels and discharged her from the practice. The Complainant also alleged that the Respondent did not have “credentials” to prescribe Xanax.

III. BOARD INVESTIGATION

5. As part of its investigation, the Board obtained a series of patient records, interviewed the Respondent and ordered a peer review of his practice.

² For confidentiality reasons, the Complainant or any patients referenced herein will not be identified by name. The Respondent may obtain the identity of any individual referenced herein by contacting the administrative prosecutor.

Patient Records

6. By letter dated December 3, 2018, the Board notified the Respondent that it had opened a preliminary investigation of the matter and provided him a copy of the Complaint. The Board directed the Respondent to provide a response to the allegations raised in the Complaint and issued him a subpoena for the Complainant's medical records.

7. On or about January 3, 2019, the Board received the Complainant's medical records from the Respondent. The Respondent, however, did not provide a written response that addressed the Complaint.

8. By letter dated March 26, 2019, the Board notified the Respondent that it had initiated an investigation, issued him a subpoena for an additional nine (9) patient records and directed him to provide summaries of care for those patients.

9. On or about April 15, 2019, the Respondent submitted the additional patient records to the Board but declined to provide summaries of care.

Interview of the Respondent

10. On May 1, 2019, Board staff interviewed the Respondent under oath, during which the Respondent disclosed that he had never taken any formal course work in pain management. He further stated that he utilizes drug contracts and urine drug screens at every visit for patients to whom he prescribes Suboxone or provides pain management treatment.

Peer Review

11. As part of its investigation, the Board referred ten (10) patient records obtained from the Respondent (referenced *infra* as "Patients 1-10") and related materials for peer review.

12. The peer review was performed by two peer reviewers who are board-certified in addiction medicine (“Peer Reviewer 1” and “Peer Reviewer 2,” respectively). On or about October 25, 2019, the peer reviewers submitted their reports to the Board.

13. The peer reviewers independently concluded that the Respondent failed to meet appropriate standards for the delivery of quality medical care in nine (9) of the ten (10) patients whose charts were reviewed.

14. The peer reviewers identified five major areas of concern with respect to the Respondent’s prescribing practices:

- i. The Respondent prescribed various combinations of controlled dangerous substances (“CDS”), such as benzodiazepines, opioids and sedative-hypnotics, to patients, and failed to provide appropriate informed consent or document or disclose the risk for concomitant use of these medications. *See e.g.*, Patient 2 (tramadol and Suboxone); Patient 3 (tramadol and Suboxone); Patient 5 (tramadol and Suboxone); Patient 8 (Ambien and Xanax); and Patient 10 Percocet and Xanax).
- ii. The Respondent did not perform comprehensive assessments to include detailed histories, thorough physical examinations or make timely referrals when necessary. *See e.g.*, Patients 1, 2, 3, 5, 6, 7, 8, 9, 10.
- iii. The Respondent regularly prescribed CDS, such as benzodiazepines and opioids, to patients with a history of substance abuse, with little justification or documentation supporting their need or efficacy, particularly when non-abusable alternatives were available. *See e.g.*, Patients 2, 3, 5 and 9.
- iv. The Respondent practiced substandard and dangerous addiction medicine when he:
 - a. Ordered urine drug screens but ignored or failed to address results indicating that patients took dangerous combinations of abused drugs and/or had not complied

with, or possibly diverted, prescribed medications. *See e.g.*, Patients 1, 2, 5, 6, 9, 10.

- b. Provided inadequate of superficial counseling to patients who abused alcohol and/or illicit drugs. *See e.g.*, Patients 2, 3, 6.
 - c. Prescribed CDS to patients with a known history of substance abuse and patients currently abusing prescription or illicit drugs, which risked relapses and/or overdoses. *See e.g.*, Patients 1, 2, 3, 5, 6, 9.
 - d. Mismanaged patients' Suboxone therapy when he provided inadequate instruction regarding the proper use of Suboxone therapy; neglected to alter his prescribed dosage based on adequacy and/or effectiveness; and failed to consider known medical conditions or non-compliance when he continued prescribing Suboxone. *See e.g.*, Patients 2, 3, 5.
- v. The Respondent failed to treat, manage and undertake follow-up plans for patients' chronic medical conditions. *See e.g.*, Patients 1, 7, 10.

Expanded Report of Peer Reviewer 1

15. After receiving the peer reviewers' findings, the Board requested that Peer Reviewer 1 provide an opinion on whether the Respondent was competent and whether his practice had the potential for patient harm.

16. Peer Reviewer 1 submitted a report dated November 14, 2019, in which he concluded that the Respondent's practice of medicine "has the potential to be a danger to his patients." In support of his conclusion, Peer Reviewer 1 identified the following concerns:

- i. First, the Respondent "recklessly prescribe[d] combinations of medicines, both controlled and uncontrolled medicines, that [had] the potential to cause significant and potentially life-threatening drug

interactions.” Further, “[the Respondent] [did] not document why he [chose] such potentially dangerous mixes of drugs” and “[did] not record whether he [had] detailed discussions with the patients about the potential dangers of the drugs he [prescribed] including the potential for drug abuse relapse.” The Respondent did not provide appropriate informed consent to these patients in these situations.

- ii. Second, “[the Respondent] fail[ed] to recognize the seriousness of his patients’ medical problems by not performing detailed histories and physicals and appropriate timely referrals when necessary. As a result, the patients’ illnesses [were] not appropriately addressed.” Peer Reviewer 1 found the Respondent’s History of Present Illness(es) were either “very superficial or non-existent” and his physical examinations were not “problem focused or detailed.” Peer Reviewer 1 cited the following examples:

- a. Patient 1:

“Patient 1 [had] very high blood pressure such as 185/125, 192/131. Throughout this case, the patient ha[d] very high often malignant hypertension. Yet [the Respondent] [did] not address this issue except to say it [was] due to cocaine abuse. He never perform[ed] the appropriate workup nor order[ed] appropriate labs to prove or disprove his theory. If he truly believe[d] [the patient’s] high blood pressures [was] due to cocaine use, he [did] not recognize the eminent danger to the patient of continued cocaine abuse. Nor [did] he address this issue of persistent cocaine abuse, [and demand] [the patient] go to an addiction treatment program.

On one visit he attribute[d] the patient’s blood pressure of 173/126 to being “stressed.” At no point in this case [did] he ever prescribe blood pressure medications.

This patient also complain[ed] of difficulty grasping objects with the left hand. This [was] ignored.”

- b. Patient 2:

“Patient [was] to have surgery for osteomyelitis in left leg. He perform[ed] a pre-op physical exam. [The Respondent identified the reason for the surgery as] ‘pre-op for left leg bone.’ No proper diagnosis [was] given. Patient also ha[d]

Hepatitis C. No liver function tests [were] ordered as part of the pre-op physical examination.”

c. Patient 3:

“Patient [3] [was] an opioid addict complaining of chronic pain from prior trauma. [The Respondent] [did] not perform a detailed history of present illness(es) or physical examination to evaluate the chronic pain issue. In fact, his very superficial physical exam [did] not prove the existence of chronic pain. Rather than refer patient to a specialist for further evaluation, the Respondent prescribe[d] oxycodone.

Patient 3 at a later appointment state[d] he might eventually harm someone. This [was] not investigated by [the Respondent]. He ha[d] no working diagnosis but prescribe[d] risperidone.”

- iii. The Respondent also regularly prescribed potentially abusable/addictive medicines, such as benzodiazepines and opioids, to patients who were actively abusing CDS, when non-abusable alternatives were available. He did not justify his decisions or acknowledge the potential risks to his patients.
- iv. In cases where patients were seen by consultants, the Respondent did not attempt to obtain the consultant note or acknowledge the recommendations. Peer Reviewer 1 cited the following example:

Patient 9:

“Patient complain[ed] of neck and back pain at the initial visit. Subsequently, an orthopedist recommend[ed] injections. There [was] no documentation that this [did] or [did not] occur. Her complaint of neck and back pain continue[d] throughout the chart. Ultimately, the patient los[t] her job due to her neck/back pain.”

- v. The Respondent practiced substandard and dangerous addiction medicine.
- a. The Respondent “persistently either ignore[d] lab-based urine drug test results proving relapses by his patients or misinterpret[ed] the results by concluding that the patient [was]

in compliance.” Peer Reviewer 1 also found that the Respondent relied too heavily on unwitnessed office-based urine drug screens that were unreliable. As a result, “[The Respondent] miss[ed] many opportunities to not only confront his patients with their continued drug abuse but to mandate professional addiction treatment. These patients were not afforded the opportunity to confront their addictive behaviors and potentially achieve sobriety.”

- b. The Respondent prescribed CDS to these patients and risked relapses and/or overdoses. He prescribed opioids to known opioid addicts and benzodiazepines to an alcohol-dependent patient.
 - c. The Respondent continued to prescribe Suboxone to patients with known medical conditions such as liver disease and pregnancy, when Subutex (pure buprenorphine) was a safer alternative. He also continued to prescribe Suboxone to a patient whose toxicology screens repeatedly showed non-compliance.
- vi. The Respondent did not have patients return for specifically designated appointments to address chronic problems (*i.e.*, hypertension, Hepatitis C, chronic pain and chronic cough) that often require frequent visits to resolve or stabilize.

The Respondent's Response

17. The Board provided the Respondent with the peer reviewers' findings. By letter dated November 20, 2019, the Respondent submitted his response. In his cover letter, the Respondent stated, “working in the inner city of Baltimore has been my toughest and most demanding challenge yet” and “the stress of working has left me with a burnt-out feeling.” The Respondent also affirmed that he reviewed each urine drug screen for the patients whose charts were peer reviewed.

CONCLUSIONS OF LAW

Based on the foregoing Investigative Findings, Panel A concludes that the public health, safety or welfare imperatively require emergency action in this case, pursuant to Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol. & 2019 Supp.) and Md. Code Regs. 10.32.02.08B(7).

ORDER

It is, by a majority of a quorum of Panel A, hereby

ORDERED that pursuant to the authority vested in the Board by Md. Code Ann., State Gov't § 10-226(c)(2) and Md. Code Regs. 10.32.02.08B(7)(a), the license of **Anthony R. Joseph, M.D.**, License Number D47529, to practice medicine in the State of Maryland is **SUMMARILY SUSPENDED**; and it is further

ORDERED that in accordance with Md. Code Regs. 10.32.02.08B(7) and E, a post-deprivation initial hearing on the summary suspension has been scheduled for **Wednesday, January 15, 2020, at 11:15 a.m.** before Disciplinary Panel A at the Maryland State Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215; and it is further

ORDERED that after the summary suspension hearing held before Panel A, the Respondent, if dissatisfied with the result of the hearing, may request within ten (10) days an evidentiary hearing, such hearing to be held within thirty (30) days of the request before an Administrative Law Judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031; and it is further

ORDERED that a copy of this Order for Summary Suspension shall be filed with the Board in accordance with Md. Code Ann., Health Occ. § 14-407 (2014 Repl. Vol. & 2019 Supp.); and it is further

ORDERED that this Order for Summary Suspension is an Order of Panel A and, as such, is a **PUBLIC DOCUMENT**. See Health Occ. §§ 1-607, 14-411.1(b)(2) and Md. Code Ann., Gen. Prov. § 4-333(b)(6).

01/08/2020
Date

Signature On File

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians