IN THE MATTER OF

EDWARD J. ARRISON, M.D.

Respondent

License Number: D50993

BEFORE THE

MARYLAND STATE

BOARD OF PHYSICIANS

Case Number: 2221-0007A

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 EDWARD J. ARRISON, M.D. (the "Respondent"), License Number D50993, to practice medicine in the State of Maryland.


INVESTIGATIVE FINDINGS

Based on information received by, and made known to Panel A, and the investigatory information obtained by, received by and made known to and available to Panel A, including the instances described below, Panel A has reason to believe that the following facts are true:

1 The statements regarding the Respondent's conduct are intended to provide the Respondent with reasonable notice of the alleged facts. 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 matter.
I. BACKGROUND

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on August 8, 1996, under License Number D50993. The Respondent’s latest license was given the expiration date of September 30, 2022.

2. The Respondent is board-certified in anesthesiology.

3. At all times relevant hereto, the Respondent was employed as a staff anesthesiologist at a health care facility (the “Facility”)² that is located in Baltimore County, Maryland.

II. PRIOR DISCIPLINARY HISTORY

2007 Consent Order

4. On April 5, 2007, the Board issued disciplinary charges against the Respondent, alleging that he violated a Disposition Agreement he entered into with the Board, dated July 31, 2003 (the “2003 Disposition Agreement”);³ and violated disciplinary provisions under the Maryland Medical Practice Act (the “Act”), Md. Code Ann., Health Occ. (“Health Occ.”) §§ 14-101 et seq.

5. The Respondent resolved these charges by entering into a Consent Order, dated July 25, 2007, in which the Board found as a matter of law that the Respondent

² For confidentiality reasons, the name of the Facility or any staff members of the Facility will not be disclosed in this document. The Respondent may obtain the identity of the Facility or any Facility staff persons upon request.

³ For confidentiality reasons, the subject matter of the 2003 Disposition Agreement will not be disclosed in this document. The Respondent is aware of the contents of the 2003 Disposition Agreement.
violated the 2003 Disposition Agreement and violated the following provisions of the Act: Health Occ. 14-404(a)(3), Is guilty of immoral or unprofessional conduct in the practice of medicine;\(^4\) and Health Occ. 14-404(a)(7), Habitually is intoxicated.\(^5\)

6. Pursuant to the 2007 Consent Order, the Board reprimanded the Respondent and placed him on probation for a minimum of five years, subject to probationary conditions including enrolling in a Board-approved program (the “Program”)\(^6\) and that he cooperate and comply with all of the Program’s recommendations and requirements; and that he provide a copy of the 2007 Consent Order to all present and future employers.

7. On January 13, 2014, the Board issued an Order Terminating Probation, in which it terminated the probation it imposed under the 2007 Consent Order.

8. The Board reviewed the findings of the 2003 Disposition Agreement and 2007 Consent Order as part of its investigation.\(^7\)

**2013 Consent Order**

9. On August 19, 2013, the Board issued disciplinary charges against the Respondent, alleging that he violated disciplinary provisions under the Act. These charges alleged that the Respondent failed to meet quality medical standards and failed to keep

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\(^4\) Health Occ. § 14-404(a)(3) has since been recodified without substantive change.

\(^5\) In its Findings of Fact, the Board also found that the Respondent provided professional services while under the influence of alcohol, in violation of Health Occ. § 14-404(a)(9)(i).

\(^6\) For confidentiality reasons, the identity of the Board-approved Program will not be disclosed in this document. The Respondent is aware of the name of the Program.

\(^7\) For confidentiality reasons, the contents of the 2003 Disposition Agreement and 2007 Consent Order will not be disclosed in this document. The Respondent is aware of the subject matter of these documents.
adequate medical records when providing pain management treatment to patients, which included prescribing controlled dangerous substances ("CDS").

10. The Respondent resolved these charges by entering into a Consent Order, dated November 7, 2013, in which the Board found as a matter of law that the Respondent violated the following provisions of the Act: Health Occ. § 14-404(a)(22), Fails to meet appropriate standards for the delivery of quality medical and surgical care performed in an outpatient surgical center, office, hospital, or any other location in this State; and Health Occ. § 14-404(a)(40), Fails to keep adequate medical records as determined by appropriate peer review.

11. Pursuant to the Consent Order, the Board reprimanded the Respondent and as a permanent condition of licensure, ordered him not to practice pain management.\(^8\)

III. CURRENT INVESTIGATIVE FINDINGS

Mandated 10-Day Report

12. The Board initiated an investigation of the Respondent after reviewing a Mandated 10-Day Report (the "Report") from the Facility, which it received on July 14, 2020. The Facility reported that the Respondent, while providing anesthesia services to patients at the Facility on July 2, 2020, "demonstrated behavior suspicious of impairment." The Facility stated that after the Respondent exhibited this behavior, it removed him from patient care and referred him for blood alcohol testing, which was positive for alcohol. The

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\(^8\) The Consent Order did permit the Respondent to order, prescribe and administer CDS, but only as part of his practice of anesthesiology, and only perioperatively.
Facility reported that on July 9, 2020, the Respondent submitted his resignation from his position at the Facility.

**Quality Assurance/Risk Management file**

13. In furtherance of the investigation, Board staff obtained the Quality Assurance/Risk Management file the Facility maintained on the Respondent. The file noted the Respondent’s toxicology findings from July 2, 2020. The Board reviewed these findings as part of its investigation.  

**Interviews of Facility health care providers**

14. The Board also interviewed two health care providers who were on duty at the Facility and interacted with the Respondent on that date: The Facility’s manager on that date, a registered nurse (the “Manager”); and the Facility’s owner and medical director, a physician (the “Medical Director”).

15. The Medical Director stated that on July 2, 2020, he was scheduled to perform 14 procedures with the Respondent, who was to provide anesthesia to the patients undergoing the procedures. The Medical Director stated that after he and the Respondent finished a number of procedures, he observed that the Respondent seemed “a little off,” noticed him “slurring of a word . . . here or there,” “acting very slow” and exhibiting other “bizarre behaviors.” The Medical Director stated that after the third procedure, he found the Respondent to be “altered.” The Medical Director stated that he approached the Manager about his concerns and together, they confronted the Respondent, who claimed

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9 For confidentiality reasons, the test findings will not be disclosed in this document. The Respondent may obtain this information from the Board upon request.
that he “had some drinks the night before.” The Medical Director stated that when he directed the Respondent to go for testing, the Respondent delayed going for a couple of hours, “dragging his feet.”

16. The Manager stated that on the morning of July 2, 2020, a recovery room nurse brought her an incomplete anesthesia sheet from a case the Respondent had done at around 7:30 a.m., after which the Manager spoke to the Medical Director because of concerns about the Respondent. The Manager stated that the Medical Director stated that the Respondent was “not himself . . . [h]e seems to be fumbling around looking for things in the anesthesia cart. It was something that was plain in sight.” The Manager stated that she and the Medical Director then confronted the Respondent and asked him if he was ill and wanted to go home. In response, the Respondent stated that he was fine but later admitted that “he did have a few drinks last night” and was concerned that he would lose his job. The Manager stated that she then relieved the Respondent of his duties and escorted him to a laboratory for blood alcohol testing. The Manager stated that she instructed the Respondent to call her after testing so that she could pick him up and take him home, but the Respondent never called her and she was later told that the Respondent’s vehicle was no longer on the Facility’s lot.

**Respondent’s August 4, 2020, letter**

17. In a letter dated July 23, 2020, Board staff requested that the Respondent provide a response to the assertion in the Report that he resigned from the Facility after he demonstrated behavior suspicious of impairment.
18. The Respondent, through legal counsel, submitted a response to the Board dated August 4, 2020, in which he provided information regarding the events that occurred at the Facility on July 2, 2020, and his current treatment status. The Respondent acknowledged that on July 2, 2020, he arrived at the Facility where a staff member, believing him to have been drinking alcohol, questioned him. The Respondent responded to the staff member by stating that he had been drinking before coming to work at the Facility. The Respondent stated that at that point, Facility personnel requested that he leave the Facility and undergo blood alcohol testing, and that he complied with this request.

19. The Respondent further acknowledged that he is “cognizant that he has had alcohol abuse problems in the past that affected his personal and professional practice,” and also acknowledged that beginning on July 14, 2020, he enrolled in in-patient treatment. The Respondent stated that as of the date of the letter, he is still enrolled.

Facility’s Procedure Records

20. Board staff reviewed Facility records for procedures performed on July 2, 2020 and determined that the Respondent provided anesthesia services to six patients during procedures, after which Facility staff confronted him about his impairment.

Respondent’s 2020 Renewal Application

21. On August 4, 2020, the Respondent completed his 2020 license renewal application (the “Application”) and electronically submitted it to the Board. In the section of the Application designated “Character and Fitness Questions,” the Board required the Respondent to answer “YES” or “NO” to a series of questions for the period since July 1, 2018 and to provide written explanations for all “YES” responses.
22. The Respondent answered "YES" to Question 3, which states: Has any licensing or disciplinary board in any jurisdiction a comparable body in the armed services or the Veterans Administration, ever filed any complaints or charges against you or investigated you for any reason?

23. The Respondent stated, "I am currently under investigation for suspected impairment."

24. The Respondent, however, answered "NO" to Question 10, which states: Do you have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a physical, mental, emotional, or nervous disorder, or condition) that in any way affects your ability to practice your profession in a safe, competent, ethical, and professional manner?

25. At the conclusion of the application, the Respondent certified that he personally reviewed all responses to the items in the application and that the information he provided was true and accurate to the best of his knowledge.

**CONCLUSIONS OF LAW**

Based upon the foregoing Investigative Findings, Panel A of the Board concludes that the public health, safety, or welfare imperatively requires emergency action, and that pursuant to State Gov't § 10-226(c)(2) and COMAR 10.32.02.08B(7), the Respondent's license is summarily suspended.
ORDER

IT IS thus, by Panel A of the Board, hereby:

ORDERED that pursuant to the authority vested in Panel A by Md. Code Ann., State Govt. § 10-226(c)(2)(2014 Repl. Vol. & 2019 Supp.) and COMAR 10.32.02.08B(7), the Respondent's license to practice medicine in the State of Maryland is hereby SUMMARILY SUSPENDED; and it is further

ORDERED that in accordance with Md. CodeRegs. 10.32.02.08B(7) and E, a post-deprivation initial hearing on the summary suspension will be held on Wednesday, September 9, 2020, at 11:15 a.m. before Panel A at the Board's offices, located at 4201 Patterson Avenue, Baltimore, Maryland, 21215-0095; and it is further

ORDERED that after the SUMMARY SUSPENSION hearing 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 set 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 21031-1301; and it is further

ORDERED that a copy of the Order for Summary Suspension shall be filed by Panel A immediately in accordance with Health Occ. § 14-407 (2014 Repl. Vol.); and it is further
ORDERED that this 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).

08/25/2020

Date

Signature on File

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