IN THE MATTER OF	*	**BEFORE THE**
ROBERT F. A. CADOGAN, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D51318	*	**Case Number: 2221-0128B**

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CONSENT ORDER

On July 11, 2022, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") charged **ROBERT F. A. CADOGAN, M.D.** (the "Respondent"), License Number D51318, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. §§ 14-101 *et seq*. (2014 Repl. Vol. & 2020 Supp.).

Panel B charged the Respondent with violating 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:
>
> . . .
>
> (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[.][1]

[1] The Respondent was also charged under Health Occ. § 14-404(a)(3)(ii), but this charge is dismissed, as set forth in the Conclusions of Law.

On September 28 2022, Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on the 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 B finds the following:

I. BACKGROUND

1. At all times relevant to these charges, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on October 18, 1996. His license is currently active.

2. The Respondent is no longer board certified in Family Medicine after his certification expired on December 31, 2017.

3. The Respondent worked at a facility from 2016 to February of 2021 providing medication assisted treatment for opioid addiction.

4. From March of 2021 to June of 2021, the Respondent was employed part-time at a facility where he treated patients for chronic pain management.

5. The Respondent is currently employed by a locum tenens agency, practicing family medicine on an Indian Reservation.

6. He does not have any hospital privileges.

II. THE COMPLAINT

7. On or about May 11, 2021, the Board received a referral from the Office of Controlled Substances Administration ("Referral"). Recent virtual inspections yielded a

concerning "pill mill" type of prescribing activity by the Respondent over the prior three months.

8. The Referral noted that oxycodone was noted to be prescribed for all patients observed and that it was often in quantities of 110.

9. Additionally, for patients under 40 years of age, the daily Morphine Milligram Equivalents (MME) for patients observed was an average of 180 MME.

10. There were families observed getting prescriptions and many traveling long distances.

III. BOARD INVESTIGATION

11. The Board opened an investigation into the Referral. In furtherance of the investigation, the Board notified the Respondent of its investigation, provided the Respondent with the Referral, directed him to submit a written response to the Referral and issued a subpoena to him for a series of patient records. The Board also obtained a peer review of the Respondent's practice and conducted an under-oath interview of the Respondent.

Patient Records

12. By letter dated June 21, 2021, the Board notified the Respondent that it had initiated an investigation of the Referral, provided him a copy of the Referral and directed

him to provide a written response to the allegations raised. The Board also issued him a *subpoena duces tecum* for the medical records of ten (10) specific patients (Patients 1-10).[2]

13. On or about July 1, 2021, the Board received a handwritten response from the Respondent indicating that he no longer had access to the patient records.

14. On or about July 15, 2021, the Board received the medical records of Patients 1-10 from the facility.

15. On or about August 5, 2021, the Board provided the Respondent a copy of the medical records received.

16. The Respondent provided summaries of care for each patient on August 26, 2021.

The Respondent's Written Response

17. In the Respondent's handwritten response to the Board dated July 1, 2021, the Respondent stated:

> "Upon my arrival at the Practice…I realized many of them [patients] needed to continue their medications. Some patients I saw in the practice I discharged from the practice if they were on probation and violated their probation or I felt they were abusing the medication. Some I reduced the amount of narcotics they were receiving, and rarely I felt the patient would need a higher dose of the narcotic they were receiving. All this to try and improve the patient's quality of life."

The Respondent's Interview

[2] For confidentiality reasons, the names of the patients will not be identified by name in this document.

18. On October 28, 2021, Board staff interviewed the Respondent under oath. When questioned about whether he had any concerns about the Facility, he stated, "I did have some concerns, there were some patients who seemed to be related." He went on to say,

> "It was just unusual that they, in some cases they happened to be in the same family. It didn't happen a lot, but I did notice that. The person in the same family had no reason to be getting it. You know, they both were, quote, unquote, in bad shape physiologically in terms of experiencing chronic pain…For example, the mom may have come in with chronic, serious back pain, her son may have had multiple gunshot wounds also, so, yes, they were justified. It's just unusual, but there's no law that says you can't see the same doctor from the same household…In retrospect, I may have said, okay, you really need to refer this person to another doctor."

19. The Respondent stated that he was the only medical personnel in the office, and therefore the de facto medical director, however he did not carry that title. Having said that, he was not familiar with the financial aspect of the practice, which insurances were accepted, or how patients paid for medical services.

20. When asked about the Referral's concern regarding prescribing greater than 90 MME's, the Respondent stated that he thought "their concerns were legitimate."

Peer Review

21. In furtherance of its investigation, the Board submitted the medical records of Patients 1-10 for a peer review. Two peer reviewers, each board-certified in pain management, independently reviewed the materials and submitted their reports to the Board.

22. In their reports, the two peer reviewers concurred that the Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to keep adequate medical records for seven (7) patients.

23. Specifically, the peer reviewers found that for seven (7) patients, the Respondent failed to meet the standard of quality medical care regarding the management of patients with substance abuse disorders for reasons including but not limited to the following areas:

(a) The Respondent failed to perform and document a thoughtful initial consultation and determine reasonable justification for the patient's ongoing opiate therapy (Patients 2, 5-10);

(b) The Respondent failed to appropriately investigate and document the origin of the patient's pain complaints, document his impressions, assess opiate risk, and devise a treatment plan. (Patients 2, 5-10);

(c) The Respondent continued to refill patient medications without completing and documenting an interim history, updating imaging studies, documenting the efficacy of treatment with pain scores, assessing opiate risks, and/or suggesting a trial of weaning. (Patients 2, 5-10);

(d) The Respondent failed to appropriately review prior records and address inconsistent urine toxicology screens with his patients, especially with those who were at high risk for misuse of prescribed opioids with Screener and

Opioid Assessment for Patients with Pain-Revised (SOAPP-R)[3] scores above eighteen (18) (Patients 5-7); Examples include but are not limited to the following:

(i) There is no documentation of the interpretation of SOAPP-R score of nineteen (19) for Patient 5, or the abnormal urine test findings that showed evidence of alcohol consumption and the non-presence of prescribed oxycodone and metabolites;

(ii) On the Respondents first visit with Patient 6 on March 11, 2021, he stated there was "low risk" for Aberrant Related Drug Behavior (ADR), despite a SOAPP-R score of twenty-one (21), a prior history of non-compliance with the prescribed opioid regimen, a previously signed probation agreement, and problematic urine tests.

(iii) Patient 7 is noted by the Respondent to be low risk for ADR despite multiple non-compliant urine tests, including on his first visit with the Respondent in March of 2021, and previously being placed on probation by a previous provider.

(iv) Respondent failed to address and document inconsistent urine toxicology screens for Patient 9 when oxycodone and metabolites appeared in the patients urine after the patient reported that they had run out of oxycodone early.

(e) The peer reviewers also independently concluded that the Respondent failed to keep adequate medical records for nine (9) patients, finding that the Respondent's medical records were consistently repetitive, lacked documentation, and failed to document justification and reasoning for continuing opioids.

[3] A Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R) score of eighteen (18) or higher indicates a significant risk for misuse of prescribed opioids.

CONCLUSIONS OF LAW

Based on the Findings of Fact, Disciplinary Panel B of the Board concludes as a matter of law that the Respondent: failed to meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in this State, in violation of Health Occ. § 14-404(a)(22); and failed to keep adequate medical records as determined by appropriate peer review, in violation of Health Occ. § 14-404(a)(40). The Health Occ. § 14-404(a)(3)(ii) charge is dismissed.

ORDER

It is, thus, by Disciplinary Panel B 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 of **SIX MONTHS.**[4] During probation, the Respondent shall comply with the following terms and conditions of probation:

1. Within **SIX MONTHS,** the Respondent is required to take and successfully complete courses in: (i) appropriate prescribing practices for opioids and benzodiazepines, and (ii) medical documentation/recordkeeping. The following terms apply:

   (a) it is the Respondent's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the courses before the courses are begun;

   (b) the Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the courses;

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

[4] If the Respondent's license expires during the period of probation, the probation and any conditions will be tolled.

(d) the Respondent is responsible for the cost of the courses; and

2. Panel B may issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program on a quarterly basis for the Respondent's Controlled Dangerous Substances ("CDS") prescriptions. The administrative subpoenas will request the Respondent's CDS prescriptions from the beginning of each quarter; 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;

ORDERED that, after the Respondent has complied with all terms and conditions or probation and after the minimum period of probation imposed by the Consent Order has passed, the Respondent may submit to the Board a written petition for termination of probation. After consideration of the petition, the Respondent's probation may be administratively terminated through an order of the disciplinary panel, if the Respondent has complied with all probationary terms and conditions and there are no pending complaints relating to the charges; 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 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* Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6).

Signature on File

10/17/2022
Date

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

CONSENT

I, Robert F. A. Cadogan, 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 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.

10/11/2022
Date

Signature on File
Robert F. A. Cadagon, M.D.
Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Prince Georges

I HEREBY CERTIFY that on this 11th day of October, 2022, before me, a Notary Public of the foregoing State and City/County, did personally appear Robert F. A. Cadogan, M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSTH my hand and seal.

Pamela Lee Baird
Notary Public

My commission expires: 6/6/2025

PAMELA LEE BAIRD
My Commission Expires
NOTARY PUBLIC
06-06-2025
PRINCE GEORGE'S COUNTY, MD