

IN THE MATTER OF  
FIDELIS F. DOH, M.D.

Respondent

License Number: D51327

\* BEFORE THE  
\* MARYLAND STATE  
\* BOARD OF PHYSICIANS  
\* Case Numbers: 2219-0156A  
\* 2220-0260A  
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**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 **Fidelis F. Doh, M.D.** (the “Respondent”), **License Number D51327**, 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.), having concluded that the public health, safety, or welfare imperatively requires emergency action.

**INVESTIGATIVE FINDINGS<sup>1</sup>**

Panel A has reasonable cause to believe that the following facts are true:

**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’s Maryland medical license on October 18, 1996, under License Number D51327. His license is active through September 30, 2020.

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<sup>1</sup> 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.

2. The Respondent is not board-certified in any medical specialty but has previously self-designated his practice areas as internal medicine and medical oncology. He currently owns and operates a clinic in Laurel, Maryland, focusing on pain management and weight loss services.

3. The Respondent holds a permit to dispense prescription drugs in the State of Maryland. The Board first issued the Respondent's Maryland dispensing permit on or about June 25, 2012, under Permit Number 2917. The dispensing permit is active through November 20, 2022.

4. The Respondent holds an active medical license in the District of Columbia. In addition to his medical practice in Maryland, the Respondent provides services as the medical intake director for the D.C. Department of Corrections.

## II. COMPLAINTS

5. From February 2019 to December 2019, the Board received six complaints about the Respondent's practice, including five complaints about his opioid prescribing practices and one complaint about his dispensing of prescription medications.

6. The first complaint, received by the Board on or about February 1, 2019, was from a pharmacy benefits manager (the "PBM").<sup>2</sup> The PBM alleged that the Respondent was "inappropriately prescribing medications containing oxycodone," among other things. The PBM provided the results of its investigation into the Respondent, which had found that his most common prescription was for oxycodone 30mg, which amounted to 53% of his total prescriptions. By comparison, the PBM pointed out that

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<sup>2</sup> To maintain confidentiality, the names of all witnesses, facilities, employees, and patients will not be used in this document but will be provided to the Respondent on request.

oxycodone 30mg ranked as the 375th most common prescription by other pain management specialists in Maryland. The PBM also noted that the Respondent rarely prescribed other pain medications such as hydrocodone, suggesting a “one-size-fits-all” approach to practicing medicine.”

7. A second complaint, dated March 22, 2019, was from the Maryland Office of Controlled Substances Administration (“OCSA”). In its complaint, OCSA summarized the findings it made over the course of several inspections, noting that the Respondent’s prescriptions had multiple “red flags,” including “high strength/quantity, cocktails, in-state long distance patients, out of state patients, and patients younger than 40 years old.” As a result, OCSA labeled the Respondent as a “prescriber of note.”

8. Three subsequent complaints, received on June 18, 2019, July 23, 2019, and September 11, 2019, were all submitted anonymously and alleged that, among other things, the Respondent was prescribing dangerously high levels of opioids and benzodiazepines.

9. The sixth complaint, received on or about December 16, 2019, was again from OCSA and based on a recent inspection of the Respondent’s office. The inspection had found multiple dispensing violations, including but not limited to expired medications mixed with regular stock, failing to provide written prescriptions to patients, non-compliant labeling, and failing to report any dispensed controlled dangerous substances (“CDS”) to the Maryland Prescription Drug Monitoring Program (“PDMP”). The inspector also noted that she observed multiple out-of-state license plates on cars in the parking lot when she arrived at the Respondent’s office for the inspection.

### **III. BOARD INVESTIGATIONS**

10. The Board initiated two investigations into the Respondent based on the complaints it received. The first investigation, under Case Number 2219-0156, focused on the Respondent's prescribing practices. The second investigation, under Case Number 2220-0260, focused on the Respondent's prescription medication dispensing practices.

#### ***A. Patient Records***

11. As part of its investigation, the Board obtained a PDMP report that listed all CDS prescriptions the Respondent wrote from January 1, 2017 to March 13, 2019. Based on the PDMP report, the Board identified ten patients who received CDS prescriptions from the Respondent during the reviewed period ("Patients 1-10").

12. By letter dated May 20, 2019, the Board notified the Respondent of the PBM's complaint and served the Respondent with a subpoena for records of Patients 1-10. On or about June 12, 2019, the Respondent provided the Board with the subpoenaed patient records and provided a treatment summary for each patient.

#### ***B. Interview of the Respondent***

13. As part of its investigation, Board staff interviewed the Respondent under oath on or about October 25, 2019.

14. The Respondent said that he completed his residency in internal medicine and fellowship training in hematology/oncology. He explained that his pain management training consisted of attending "pain week" trainings once every two years, attending "pain weekend" trainings when available, and "keep[ing] up with all of the pain literature."

15. The Respondent admitted that he has prescribed medications to patients from West Virginia. He also explained his procedure that if a patient has a “dirty urine,” he will first “send them to a drug program,” and for “substance abuse counseling.” According to the Respondent, if a patient has a second inconsistent urine drug screen, he will “discharge them with a 30-day supply of medicine.”

### *C. Peer Review*

16. As part of its investigation, the Board referred ten patient records obtained from the Respondent (Patients 1-10) and related materials to a peer review entity.

17. Two peer reviewers (“Peer Reviewers 1 and 2”), who are board-certified in pain management and physical medicine/rehabilitation, separately reviewed the ten patient records and submitted their individual reports to the Board.

18. The peer reviewers concurred that the Respondent did not meet the standard of quality care for all ten patients for reasons including, but not limited to:

- a. The Respondent prescribed and maintained non-cancer patients on high doses of opioids ranging from approximately 90 to 390 MME<sup>3</sup> per day (Patients 1-10). The Respondent prescribed all ten patients over 200 MME per day at some point over the course of their treatment;
- b. The Respondent failed to reduce or make a concerted effort to attempt to reduce opioid doses to 90 MME per day or below (Patients 1-10);
- c. The Respondent continued to prescribe and refill opioids in the presence of “inconsistent” drug screens (positive for illicit substances, positive for non-prescribed narcotics, and/or negative for prescribed opioids) or other aberrant behavior (self-escalation) with no documented attempts

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<sup>3</sup> Morphine Milligram Equivalence (“MME”) is a value assigned to each opioid to represent its relative potency by using morphine as the standard comparison. The *CDC Guideline for Prescribing Opioids for Chronic Pain* (the “CDC Guideline”) uses MME to establish a recommended opioid dosing and recommends using precaution when prescribing opioid doses greater than or equal to 50 MME per day and avoiding or carefully justifying a decision to increase opioid doses greater than or equal to 90 MME per day.

to refer patients for substance abuse treatment and counseling, taper the patients off opioids, or discharge the patients from his practice (Patients 1-10);

- d. The Respondent increased patients' opioid doses based on subjective complaints of pain but failed to document objective findings to carefully justify increasing opioid doses significantly above the CDC Guideline (Patients 1-10);
- e. The Respondent failed to consider or refer patients for alternative treatments such as physical or chiropractic therapy, and/or interventional injection treatments (Patients 1, 4, 5, 6, 7, and 10);
- f. The Respondent failed to require that patients obtain EKG studies to assess any cardiac changes from certain opioids (Patients 5 and 8); and
- g. The Respondent prescribed benzodiazepines to patients who were also prescribed high-dose opiates without verifying anxiety diagnoses with a mental health provider, and without providing appropriate or accurate counseling on how to avoid dangerous or fatal interactions between the drugs (Patients 2, 4, 6, and 8).

#### ***D. Supplemental Report of Peer Reviewer 2***

19. On May 2, 2020, Peer Reviewer 2 wrote a letter to the Board supplementing his previously submitted peer-review report. Peer Reviewer 2 expressed his concern about the Respondent's "clear pattern of excessive opioid prescribing," and his "proclivity for dangerous opioid prescribing habits and extremely risky treatment patterns[.]" Peer Reviewer 2 also wrote that the "overwhelming evidence [shows] that most of the patients [ ] reviewed had a Substance Use Disorder . . . and [the Respondent] ignored clear indications that these patients needed Substance Use Disorder treatments and were being placed at greater risk by continuing to prescribe opioids to them."

20. Peer Reviewer 2 further noted that the Respondent does not accept insurance and requires all patients to pay in cash at the time of their appointments.

According to Peer Reviewer 2, this fact, coupled with the Respondent's overlooking of his patients' aberrant behavior, is consistent with an individual trying to "feed his practice . . . for profit."

21. Peer Reviewer 2 concluded that the Respondent "is not qualified by the spectrum of his training and evidence of his practice habits to treat pain related conditions," and the Respondent "should not be permitted to treat pain patients using [CDS]."

***E. The Respondent's Response to Peer Review Reports***

22. On or about May 14, 2020, the Respondent submitted a response to the Board after being provided copies of the peer reviewers' reports. The Respondent stated that, among other things, he is "aware of the current standard of less than 90 MME/day of oral morphine," but that "the CDC also indicated that this is just a guideline and mostly applies to primary care providers." The Respondent also stated that he treats patients "holistically" and must "thread the needle" to make sure remedial actions such as discharging patients with aberrant behavior "were not taken at the wrong time during their treatment[.]"

***F. The Respondent's Dispensing Practices***

23. On or about December 7, 2018, OCSA inspected the Respondent's office. The inspectors noted in their inspection report that the Respondent stocked and dispensed phentermine (a Schedule IV CDS), among other weight-loss medications and antibiotics. The inspectors found multiple violations, including:

- a. Incomplete record of all stocks of CDS on hand;
- b. The Respondent did not provide written prescriptions to patients;

- c. No signs were prominently displayed advising patients that prescription drugs may be purchased if a pharmacy is not conveniently located;
- d. There were no signed forms in patient charts to confirm that a pharmacy was not conveniently located to the patient;
- e. Labeling did not include the date dispensed and provided an improper expiration date;
- f. The Respondent dispensed prescriptions in pre-filled plastic bags, not in required child-proof containers;
- g. The Respondent did not do final checks before medications were being dispensed to patients; and
- h. The Respondent did not report CDS to PDMP within three days of being dispensed to patients.

24. During the interview of the Respondent on October 25, 2019 (*see ¶¶ 13-15, above*), Board staff asked about the 2018 OCSA inspection. The Respondent told Board staff that he had corrected the violations that the OCSA inspectors had cited, although he admitted he had not started reporting CDS prescriptions to PDMP as required. He stated that he was “not an active pharmacy” and had not dispensed phentermine for “the last . . . six or so months.”

25. On or about December 13, 2019, OCSA again inspected the Respondent’s office. The inspector found multiple dispensing violations, including:

- a. Expired medications were mixed in with regular stock;
- b. Staff was unable to locate a record of all CDS stock on hand;
- c. The Respondent did not provide written prescriptions to patients;
- d. Labeling did not include the date dispensed, provided an improper expiration date, and did not include handling or storage instructions;
- e. Staff was unable to provide distributor information; and
- f. The Respondent did not report CDS to PDMP within three days of being dispensed to patients.



26. The inspector observed a log of prescriptions that had the Respondent had dispensed in 2018 and 2019. Included in the log were phentermine prescriptions that the Respondent had dispensed through October 24, 2019, which contradicts the Respondent's statements made under oath to Board staff the following day that he had not dispensed phentermine since approximately April 2019 (*see ¶ 24, above*).

27. By letter dated January 23, 2020, the Board notified the Respondent that it had opened an investigation into his dispensing practices based on the most recent OCSA complaint and requested that he provide a written response.

28. On or about February 6, 2020, the Respondent provided his written response to the OCSA complaint. The Respondent claimed that "the staff member responsible for bringing us into full compliance . . . was let go in May 2019[.]" The Respondent also noted that he has stopped dispensing all medications as of October 2019.

### **CONCLUSION 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)(a).

### **ORDER**

Based on the foregoing Investigative Findings and Conclusion of Law, 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

**FIDELIS F. DOH, M.D.**, License Number D51327, to practice medicine in the State of Maryland is **SUMMARILY SUSPENDED**; and it is further

**ORDERED** that a post-deprivation summary suspension hearing in accordance with Md. Code Regs. 10.32.02.08E has been scheduled for **Wednesday, June 10, 2020, at 1:00 p.m.** before Disciplinary Panel A at the Maryland State Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215; and it is further

**ORDERED** that at the conclusion of the post-deprivation 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 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).

05/26/2020  
Date

***Signature on File***

Christine A. Farrelly  
Executive Director  
Maryland State Board of Physicians