IN THE MATTER OF	*	**BEFORE THE**
DIAA Y. MIKHAIL, M.D.,	*	**MARYLAND STATE**
Respondent.	*	**BOARD OF PHYSICIANS**
License Number: D51883	*	**Case Numbers: 2221-0023**

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

FINAL DECISION AND ORDER

PROCEDURAL HISTORY

Diaa Y. Mikhail, M.D., is a board-certified family medicine physician, originally licensed to practice medicine in Maryland in 1997. On February 16, 2021, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") charged Dr. Mikhail with unprofessional conduct in the practice of medicine, willfully making or filing a false report or record in the practice of medicine, and with violating a provision of the Maryland Medical Practice Act, a rule or regulation adopted by the Board or any State or federal law pertaining to the practice of medicine. *See* Md. Code Ann., Health Occ. § 14-404(a)(3)(ii), (11), (43). The charges alleged that Dr. Mikhail treated a family member for years, including prescribing numerous medications including Controlled Dangerous Substances (CDS), and wrote prescriptions in one family member's name for her to fill the prescription and deliver it to another family member overseas.

On September 27 and 28, 2021, an Administrative Law Judge ("ALJ") held an evidentiary hearing at the Office of Administrative Hearings. At the hearing, the State introduced twenty-one exhibits that were accepted into evidence and one that was rejected. The State presented testimony from the Board's compliance analyst and a physician who was qualified as an expert in internal medicine, gastroenterology, and professional ethics. Dr. Mikhail introduced six exhibits, testified on his own behalf, and presented testimony from a

physician who was qualified as an expert in infectious disease, internal medicine, and primary care medicine. On January 4, 2022, the ALJ issued a proposed decision concluding that, as a matter of law, that Dr. Mikhail committed unprofessional conduct in the practice of medicine, Health Occ. § 14-404(a)(3)(ii); willfully made or filed a false report or record in the practice of medicine, Health Occ. § 14-404(a)(11); and violated provisions of the Maryland Medical Practice Act, a rule or regulation adopted by the Board or any State or federal law pertaining to the practice of medicine. Health Occ. § 14-404(a)(43). As a sanction, the ALJ recommended a stayed suspension, conditioned on Dr. Mikhail's completion of courses in medical record keeping and medical ethics within six months, a two-year probationary period, and payment of a $10,000 fine.

Dr. Mikhail filed exceptions to the sanction recommended in the ALJ's proposed decision. Dr. Mikhail did not take exception to the ALJ's findings of fact or conclusions of law. On June 8, 2022, both parties appeared before Disciplinary Panel A of the Board for an exceptions hearing.

FINDINGS OF FACT

The Panel adopts the Stipulation of Facts ¶¶ 1-10 and the ALJ's undisputed Proposed Findings of Fact ¶¶ 1-40 and incorporates them by reference into the body of this document as if set forth in full. *See* attached ALJ Proposed Decision, Exhibit 1. The Panel also adopts the ALJ's discussion section in full (pages 14-24). Ex. 1. The findings of fact were proven by the preponderance of the evidence.

ANALYSIS

Treatment of Family Member 1

The ALJ found and the Panel upholds a finding that Dr. Mikhail is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii), for treatment of members of his family. Unprofessional conduct is "conduct which breaches the rules or ethical code of a profession or conduct which is unbecoming a member in good standing of a profession." *Finucan v. Board of Physicians*, 380 Md. 577, 593 (2004). Additionally, unprofessional conduct includes acts that are commonly understood by the profession to be prohibited. *See Salerian v. Maryland State Board of Physicians* 176 Md. App. 231, 248 (2007). In both *Salerian* and *Finucan* the courts approved the use of the AMA Guidelines and an opinion of the AMA's Council on Ethical and Judicial Affairs, respectively, in determining whether the conduct at issue was unprofessional. *Salerian*, 176 Md. App. at 249; *Finucan*, 380 Md. at 593. The Board's regulations provide that "the disciplinary panels may consider the Principles of Ethics of the American Medical Association." COMAR 10.32.02.16. The American Medical Association ("AMA") Code of Medical Ethics' Opinion on Physicians Treating Family Members (Opinion 8.19) and the AMA's Code of Medical Ethics Opinion 1.2.1 were admitted into evidence and considered by the State's expert in reaching her conclusion that Dr. Mikhail's conduct was unprofessional.

Ethics Opinion 8.19 states "[p]hysicians generally should not treat . . . members of their immediate family." The opinion discusses how "[p]rofessional objectivity may be compromised when an immediate family member . . . is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered." The ethics opinion states that "[p]hysicians may fail to probe sensitive areas

when taking the medical history," and that, "[s]imilarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination." Finally, the opinion states, "[e]xcept in emergencies, it is not appropriate for physicians to write prescriptions for controlled dangerous substances for . . . family members."

The ALJ found that the restrictions and limitations on treatment of family members was widely understood in the profession and that Dr. Mikhail's treatment of family members breached an ethical code of physician practice. The Panel adopts these ALJ findings. The AMA's adoption and publication of its stance against physicians treating family members in ethics opinions, the Board's history of discipline against physicians for treating family members, and testimony from Dr. Mikhail and the State's expert recognizing the restrictions on treating family members together establish that treatment of family members for long-term, non-emergency treatment was commonly understood by licensed physicians to be unprofessional conduct.

Dr. Mikhail acted as Family Member 1's primary care physician from 1998 until 2020. He treated her for various conditions including psychiatric conditions and prescribed various medications for chronic and acute conditions including one Controlled Dangerous Substance and medications for psychiatric care. The ALJ found, and the Panel agrees, that Dr. Mikhail's treatment was not short-term care, emergency treatment, or care rendered because no other providers were available. Some of the risks suggested by the AMA opinions presented themselves here. Family Member 1 was not candid about her other conditions and treatment, failing to tell Dr. Mikhail about concurrent treatment. Dr. Mikhail's treatment of Family Member 1 for her psychiatric conditions included sensitive symptoms and topics that, as the State's expert explained, may have caused discomfort to Family Member 1 and her conditions therefore were not fully probed by Dr. Mikhail. He acknowledged that it was difficult to set

boundaries. Further, Dr. Mikhail's treatment was informal, outside of the office, and he failed to treat Family Member 1 as he treated other patients as demonstrated by his failure to keep progress notes (medical records), including for his prescribing of medications including CDS.

Treatment of Family Member 2

Dr. Mikhail also prescribed medication for Family Member 2 from 2013 to 2020. Again, the treatment was not emergency care, short term care, or care rendered until another provider became available. Family Member 2 resided in another country and Dr. Mikhail did not make periodic examinations, maintain records, or even speak with Family Member 2's primary treating physician, instead relying on Family Member 2 to keep him updated about other medications that Family Member 2 was taking.

Dr. Mikhail, however, did not write prescriptions to Family Member 2. Instead of writing prescriptions in Family Member 2's name, Dr. Mikhail wrote the prescriptions for Family Member 1 who would then fill the prescription locally at a pharmacy and then transport the medication to Family Member 2 abroad through intermediaries who happened to be traveling to Family Member 2's location outside the United States. Dr. Mikhail intentionally wrote those prescriptions in the wrong name. "Willfully" making a false report "requires proof that the conduct at issue was done intentionally, not that it was committed with the intent to deceive or with malice." *Kim v. Maryland State Bd. of Physicians*, 423 Md. 523, 546 (2011). Dr. Mikhail acknowledged that he knowingly, willingly, and voluntarily made untrue statements in writing that the prescriptions in Family Member 1's name when the medications were intended for Family Member 2 to use.

CONCLUSIONS OF LAW

Based on the foregoing conduct, Disciplinary Panel A concludes, as a matter of law, that Dr. Mikhail acted unprofessionally in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii), with respect to Family Member 1 and 2, made or filed a false report or record in the practice of medicine, in violation of Health Occ. § 14-404(a)(11), with respect to Family Member 2, and violated provisions of this title, rule or regulations adopted by the Board, or State or federal laws pertaining to the practice of medicine, in violation of Health Occ. § 14-404(a)(43), with respect to Family Member 1 and Family Member 2.

SANCTION

As a sanction, the ALJ recommended that the Board impose a stayed suspension, two years of probation, courses in record keeping and ethics, and a $10,000 fine. The ALJ explained that the Board's mission is to protect the public and not to punish physicians. The ALJ cited the sanctioning guidelines, which provide for sanctions between a reprimand and revocation for grounds (3) and (11) and a fine between $5,000 and $50,000 for unprofessional conduct and between $10,000 and $50,000 for filing a false report. COMAR 10.32.02.10B. The ALJ recognized applicable mitigating factors finding that Dr. Mikhail was unaware of the violation for treating family members, as it was normal practice where he was trained in Egypt. The ALJ found that, while his ignorance does not excuse the conduct, it does impact his culpability. The ALJ also found that Dr. Mikhail willfully created false records with respect to the prescription intended for Family Member 2, and, though it was motivated by a desire to assist Family Member 2, the ALJ found that his false prescribing was willful. The ALJ also noted that the lack of medical records for both family members and his lack of examination for Family Member 2 created potential for injury. The aggravating factor is the length of the violation because Dr.

Mikhail's conduct occurred over a period of many years. The ALJ found, based on Dr. Mikhail's testimony, his cooperation with the Board's investigation, his cessation of the prescribing practices after the charges were issued, and his demeanor, that he is unlikely to resume the prescribing to family members, which demonstrated rehabilitative potential.

Dr. Mikhail takes exception to the ALJ's proposed sanction and argues that the Board should remove the stayed suspension and decrease the $10,000 fine. Dr. Mikhail argues that a stayed suspension would not protect the public and is needlessly punitive. Dr. Mikhail focuses on the ALJ's finding that Dr. Mikhail was "unlikely to resume these practices" and exhibited "rehabilitative potential." Dr. Mikhail noted that he had not acted for financial or nefarious reasons and was unaware of the ethical prohibitions on treating family members. Dr. Mikhail also argues that a stayed suspension could affect his patients, causing him to lose his board certification and credentials with his current insurance plan. Dr. Mikhail also recounted the mitigating factors: He has no disciplinary history, he voluntarily disclosed the violations and cooperated in the investigation, he was not motivated by financial considerations, he had no ill intent, and he claims he committed an unknowing violation. For the same reasons, Dr. Mikhail also argued that the fine was excessive given the circumstances.

The State argues that Dr. Mikhail's conduct was significant. He treated Family Member 1 for complex, chronic conditions, including prescribing CDS. The Ethics Opinions note the inherent dangers that exist when treating family members. The State argues that it is unlikely that he was unaware of the Board's general prohibition against physicians treating family members based on the Board's warnings over the years through newsletters, and numerous orders. Further, the State notes that false prescriptions were also written for Family Member 2 in the name of Family Member 1, which was an intentional falsification of a medical record. The

State explains that Dr. Mikhail willfully and knowingly engaged in this practice for many years. The State recommends adopting the ALJ's proposed decision and recommended sanction in full.

The Panel has considered the mitigating factors that apply Dr. Mikhail's case, including his lack of disciplinary history, his voluntary admission of the misconduct, his cooperation with the investigation, and his rehabilitative potential. COMAR § 10.32.02.09(B)(5). The Panel has also considered the aggravating factors including, the deliberate false report, the potential for patient harm, and the pattern of conduct for approximately twenty years of treating Family Member 1 and seven years of treating Family Member 2. COMAR § 10.32.02.09(B)(6).

The Panel finds that Dr. Mikhail's conduct was serious. Whether or not he was aware of the ethical rule that treatment of family members was prohibited, he intentionally treated his family members for many years. He also treated his family members differently than other patients. He treated Family Member 1 at his home. He never kept medical records for either Family Member 1 for the twenty-two years he treated Family Member 1 or Family Member 2 for the seven years treating Family Member 2. He did not examine Family Member 2 and did not consult with Family Member 2's primary physician. His lack of knowledge regarding the ethics of treating family members or the need to keep medical records, even for family members, is troubling.

But more importantly, Dr. Mikhail made false representations, issuing prescriptions to Family Member 2 in Family Member 1's name for approximately seven years. Dr. Mikhail prescribed to Family Member 2 by writing false prescriptions for Family Member 1 with the intent and knowledge that Family Member 1 would fill the prescriptions and send those prescriptions internationally, through intermediaries, to Family Member 2. Dr. Mikhail did so willfully, and these false prescriptions are not due to a lack of training or based upon different

ethical standards between Egypt, where Dr. Mikhail trained, and the United States. His actions were done knowingly, willingly, voluntarily, and deceptively.

Based on his intentional writing of false prescriptions, Dr. Mikhail's arguments fall apart. His claim that he deserves a lesser sanction because of his "unknowing violation" and his being unaware "of the ethical prohibition here" are fully focused on his prescribing to family members and he simply ignores the alarming willful violation regarding false prescriptions for Family Member 2. Dr. Mikhail acknowledges that he knew that was not acceptable behavior to write those false prescriptions, and yet he did it anyway. Based on its mandate of public protection, the Panel believes that a meaningful sanction must reflect the serious nature of the false prescriptions written by Dr. Mikhail. The Panel will impose a suspension for one week to impress upon Dr. Mikhail that writing false prescriptions will not be tolerated. Ultimately, the Panel agrees with the ALJ's assessment that Dr. Mikhail has rehabilitative potential, and the short duration of the suspension reflects the Panel's intention to give Dr. Mikhail a second chance.

The Panel, thus, rejects Dr. Mikhail's arguments regarding imposing a suspension and will also impose a reprimand. The Panel accepts the ALJ's recommended sanction in part; and accepts the ALJ's recommended two-year probationary period, recordkeeping course, ethics course, and fine. The Panel modifies the ALJ's recommended sanction, in part, and imposes a suspension of five business days and imposes a reprimand.

ORDER

It is, by an affirmative vote of a majority of a quorum of Disciplinary Panel A, hereby

ORDERED that **DIAA Y. MIKHAIL, M.D.**, is **REPRIMANDED**; and it is further

ORDERED that Dr. Mikhail is **SUSPENDED** for a period of **FIVE (5) BUSINESS DAYS**; and it is further

ORDERED that after five business days, Board Disciplinary Panel A will administratively terminate the suspension. The administrative termination of suspension will be issued through an order of the Board or Board panel; and it is further

ORDERED that Dr. Mikhail is placed on **PROBATION** for a minimum period of **TWO (2) YEARS.**[1] During the probationary period, Dr. Mikhail shall comply with the following probationary terms and conditions:

(1) Within **SIX (6) MONTHS**, Dr. Mikhail is required to take and successfully complete two courses: (1) medical recordkeeping and (2) professional ethics. The following terms apply:

(a) It is Dr. Mikhail's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the course before the course is begun;

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

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

(d) Dr. Mikhail is responsible for the cost of the courses;

(2) within **ONE (1) YEAR,** Dr. Mikhail shall pay a civil fine of **TEN THOUSAND (10,000) DOLLARS**. 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 Dr. Mikhail's license if Dr. Mikhail fails to timely pay the fine to the Board; it is further

ORDERED that, after Dr. Mikhail has complied with all terms and conditions of probation and the minimum period of probation imposed by the Consent Order has passed, Dr. Mikhail may submit to the Board a written petition for termination of probation. After consideration of the petition, the probation may be terminated through an order of the disciplinary panel. Dr. Mikhail may be required to appear before the disciplinary panel to discuss

[1] If Dr. Mikhail's license expires while he is on probation, the probationary period and any probationary conditions will be tolled. COMAR 10.32.02.05C(3).

his petition for termination. The disciplinary panel may grant the petition to terminate the probation, through an order of the disciplinary panel, if Dr. Mikhail has complied with all probationary terms and conditions and there are no pending complaints relating to the charges; and it is further

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

ORDERED that the effective date of the Order is the date the Order is signed by the Executive Director of the Board or her designee. The Executive Director or her designee signs the Order on behalf of the disciplinary panel which has imposed the terms and conditions of this Order; and it is further

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

ORDERED that, if Dr. Mikhail allegedly fails to comply with any term or condition imposed by this Order, Dr. Mikhail 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, Dr. Mikhail 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 Dr. Mikhail has failed to comply with any term or condition imposed by this Order, the disciplinary panel may reprimand Dr. Mikhail, place him on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke his 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 Dr. Mikhail; and it is further

ORDERED that this Order is a public document. *See* Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6).

07/29/2022
Date

Signature On File

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

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 14-408(a), Dr. Mikhail has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within 30 days from the date of mailing of this Final Decision and Order. The cover letter accompanying this final decision and order indicates the date the decision is mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Dr. Mikhail files a petition for judicial review, the Board is a party and should be served with the court's process at the following address:

Maryland State Board of Physicians
Christine A. Farrelly, Executive Director
4201 Patterson Avenue
Baltimore, Maryland 21215

Notice of any petition should also be sent to the Board's counsel at the following address:

David S. Finkler
Assistant Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

Exhibit 1

IN THE MATTER OF:	*	**BEFORE EMILY DANEKER,**
DIAA Y. MIKHAIL, M.D.,	*	**AN ADMINISTRATIVE LAW JUDGE**
LICENSE No.: D51883,	*	**OF THE MARYLAND OFFICE OF**
RESPONDENT	*	**ADMINISTRATIVE HEARINGS**
	*	**OAH CASE NO.: MDH-MBP2-71-21-13038**[1]

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

PROPOSED DECISION

STATEMENT OF THE CASE

On February 16, 2021, the Maryland Board of Physicians (Board) Disciplinary Panel B caused charges to be issued against Diaa Y. Mikhail, M.D., (Respondent) for alleged violations of the State law governing the practice of medicine. Specifically, the Respondent is charged under section 14-404 of the Health Occupations Article with:

- unprofessional conduct in the practice of medicine;
- willfully making or filing a false report or record in the practice of medicine; and

[1] The file originally was designated as case number MDH-MBP2-72-21-13038 (an emergency disciplinary suspension designation), though some documents contained the case designation listed above (a non-emergent disciplinary designation); the parties confirmed that the emergency suspension designation was incorrect.

- violating any provision of the Act (aside from the licensure process described under subtitle 3A), any rule or regulation adopted by the Board, or any State or federal law pertaining to the practice of medicine.

Md. Code Ann., Health Occ. § 14-404(a)(3), (11), (43) (2021);[2] Code of Maryland Regulations (COMAR) 10.32.02.03E(3)(d); *see also* COMAR 10.32.02.16. The disciplinary panel referred the matter to the Office of the Attorney General for prosecution. COMAR 10.32.02.03E(5), (7); *see also* COMAR 10.32.02.02B(3). Attempts at resolution through the Disciplinary Committee for Case Resolution process were unsuccessful, and the matter was referred to the Office of Administrative Hearings (OAH) for a hearing and to issue proposed findings of fact, proposed conclusions of law, and a proposed disposition. COMAR 10.32.02.E(9)(b); COMAR 10.32.02.04B(1).

I held an in-person hearing on September 27 and 28, 2021,[3] at the OAH. Health Occ. § 14-405(a); COMAR 10.32.02.04. David J. McManus, Esquire, represented the Respondent. Robert Gilbert, Assistant Attorney General, was assigned by the Office of the Attorney General to prosecute the charges. COMAR 10.32.02.03E(5), F(2), (3).

Procedure is governed by the contested case provisions of the Administrative Procedure Act, the Rules for Hearings Before the Board of Physicians, and the Rules of Procedure of the OAH. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2021); COMAR 10.32.02; COMAR 28.02.01.

[2] Although the charges are based on conduct extending back for a period of years and were filed prior to the publication of the 2021 replacement volume of the Health Occupations Article, section 14-404, subparagraphs (a)(3) and (a)(11) have been in effect since at least 2003 and subparagraph (a)(43) has been in effect since July 2019, all without substantive change. Thus, for convenience, all subsequent references to the Health Occupations Article are to the 2021 replacement volume, unless otherwise indicated.

[3] The record was held open until October 8, 2021 for the parties to submit written closing arguments.

ISSUES

1. Did the Respondent violate subsections 14-404(a)(3), (11), or (43) of the Health Occupations Article?

2. If the Respondent violated one or more of those provisions, what is the appropriate sanction?

SUMMARY OF THE EVIDENCE

Testimony

The administrative prosecutor presented the following witnesses in support of the charges: Alexandra Fota, a compliance analyst with the Board, and [redacted], M.D., who was accepted as an expert in internal medicine, gastroenterology, and professional ethics.

The Respondent testified in his own behalf, and presented testimony from [redacted], M.D., who was accepted as an expert in infectious disease, internal medicine, and primary care medicine.

Exhibits

On behalf of the State, the administrative prosecutor offered the following exhibits, which were admitted into evidence:

State Ex. 1 - Physician Profile Portal licensing information, printed June 1, 2021

State Ex. 3 - Subpoena issued by the Board to the Respondent, August 7, 2020

State Ex. 4 - Letter from counsel for Respondent to the Board, August 19, 2020

State Ex. 4A - Records enclosed with August 19, 2020 letter (Bates pages 00011 to 41)

State Ex. 5 - Letter from the Board to the Respondent, October 6, 2020

State Ex. 6 - Transcript of Board's Examination Under Oath of Respondent, October 27, 2020

State Ex. 7A - Cover letter and subpoena issued by the Board to Giant Pharmacy #348, October 27, 2020

State Ex. 7B - Cover letter and subpoena issued by the Board to Safeway Pharmacy #1553, October 27, 2020

State Ex. 7C - Subpoena issued by the Board to Giant Pharmacy #348, November 2, 2020

State Ex. 7D - Cover letter from Albertsons Companies (Safeway) to the Board, with enclosed documents, November 4, 2020

State Ex. 7E - Documents from Giant Pharmacy #348, November 2, 2020 (Bates pages 00085 to 94)

State Ex. 7F - Cover letter and subpoena issued by the Board to [redacted] Giant Pharmacy Operations, November 19, 2020

State Ex. 7G - Cover letter and subpoena issued by the Board to [redacted], Giant Pharmacy Operations, December 4, 2020

State Ex. 7H - Documents from [redacted] Giant Pharmacy Operations, December 21, 2020 (Bates pages 00099 to 141)

State Ex. 7I - Subpoena issued by the Board to Safeway Pharmacy #1553, January 6, 2021; Emails between the Board and [redacted], Pharmacy Professional Services Department, Albertsons Companies, January 6 to 18, 2021; Documents from Safeway Pharmacy #1553 (Bates pages 000152 to 242)

State Ex. 8. - Board's Report of Investigation, January 27, 2021,[4] exclusive of the Prior Board History

State Ex. 9 - American Medical Association (AMA) Code of Medical Ethics, Opinion No. 8.19, May 2012 (printed from the website on September 11, 2019)

State Ex. 10 - AMA Code of Medical Ethics, Opinion No. 1.2.1, undated

State Ex. 11 - Curriculum vitae for Dr. [redacted], undated

State Ex. 12 - Dr. [redacted]'s written opinion, July 6, 2021

State Ex. 13 - *In re Ralph B. Epstein, M.D.*, Board Case Number 2218-0269, Final Decision and Order, June 3, 2020, with the attached underlying Proposed Decision issued by the Office of Administrative Hearings, January 9, 2020

[4] As Ms. Fota explained in her testimony, this report was erroneously dated with the year 2020.

The State also offered a June 20, 2012 letter, identified as its exhibit number two, into evidence. Although the Respondent's objection to that exhibit was sustained, a copy of the exhibit is maintained with the file. COMAR 28.02.01.22C. A copy of the Charges was included as the State's exhibit 14 for reference purposes only. The State also used a list of [redacted] that the Respondent prescribed for [redacted] during its cross-examination of Dr. [redacted] The list was identified as the State's exhibit fifteen; although it was not moved into evidence, a copy is retained with the administrative record. *Id.*

The Respondent offered the following exhibits, which were admitted into evidence:

Resp. Ex. 1 - Curriculum vitae for Dr. [redacted] undated

Resp. Ex. 2 - Written opinion of Dr. [redacted] undated

Resp. Ex. 3 - Email from the American Board of Family Medicine (ABFM) to the Respondent, re: Revised Guidelines for Professionalism, Licensure, and Personal Conduct (approved April 26, 2021), email dated May 26, 2021

Resp. Ex. 4 - ABFM Guidelines for Professionalism, Licensure, and Personal Conduct, Version 2018-7, effective April 30, 2018

Resp. Ex. 5 - ABFM Guidelines for Professionalism, Licensure, and Personal Conduct, Version 2021-1, effective April 26, 2021

Resp. Ex. 6 - *In re Peter G. Uggowitzer, M.D.*, Board Case Number 2219-0200B, Consent Order, June 19, 2020

The parties jointly offered the following exhibits, which were admitted into evidence:

Jt. Ex. 1 - Excerpt from Board's Winter 2012 Newsletter, *Taking Care of Family Members*

Jt. Ex. 2 - Dr. [redacted]s precedent reference list, undated

STIPULATIONS OF FACT

The parties stipulated to the following facts:[5]

1. The Board originally issued a Maryland medical license to Dr. Mikhail on April 18, 1997,[6] under License Number D51883. Dr. Mikhail has maintained continuous licensure in Maryland since that time. Dr. Mikhail's license is active through September 30, 2023.

2. Dr. Mikhail is board-certified in family medicine and practices at a medical office at 1005 North Point Road, Suite 708, Baltimore, Maryland 21224.

3. In 2020, the Board initiated an investigation of Dr. Mikhail.

4. As part of its investigation, the Board, through a *subpoena duces tecum* (document subpoena) to Dr. Mikhail dated August 7, 2020,[7] directed Dr. Mikhail to produce the medical records of [redacted].

5. Dr. Mikhail responded through a letter from his counsel, David J. McManus, Jr., dated August 19, 2020. In this letter, Dr. Mikhail disclosed that [redacted] was [redacted][8] Dr. Mikhail also provided certain medical records with respect to [redacted]

6. By letter dated October 6, 2020, the Board notified Dr. Mikhail that it had initiated an investigation of him under Case Number 2221-0023B. The letter contained a *subpoena ad testificandum* for him to participate in a teleconference interview with the Board.

7. On October 27, 2020, Board staff conducted an interview under oath of Dr. Mikhail. Dr. Mikhail was represented by Mr. McManus during the interview. The interview was subsequently transcribed.

---

[5] A copy of the written Joint Stipulations is included in the administrative record. I have made non-substantive alterations to the stipulated facts where needed for format, clarity, and readability.

[6] At that time, the Board was called the Maryland State Board of Physician Quality Assurance.

[7] The Joint Stipulation specifies that this occurred on August 7, 2021; the subpoena is in evidence and reflects a date of August 7, 2020, which is consistent with the remainder of the timeline. *See* State Ex. 3.

[8] [redacted] will at times be referred to as [redacted]

8. The Board then issued a series of document subpoenas to area pharmacies for any prescriptions Dr. Mikhail wrote for [redacted]. The subpoenas, and the responses received, are as follows:

a. Letter and document subpoena to Giant, October 27, 2020
b. Letter and document subpoena to Safeway, October 27, 2020
c. Document subpoena to Giant, November 2, 2020
d. Response from Albertsons (Safeway), November 4, 2020
e. Response from Giant, November 10, 2020
f. Letter and document subpoena to Giant, November 19, 2020
g. Letter and document subpoena to Giant, December 4, 2020
h. Response from Giant, December 21, 2020
i. Response from Safeway, January 7, 2021

9. On January 27, 2021, the assigned investigator, Alexandra Fota, filed a Report of Investigation in this matter.

10. On February 13, 2021, Disciplinary Panel B of the Board issued Charges Under the Maryland Medical Practice Act against the Respondent, under Case Number 2221-0023B, alleging violations of Health Occupations Article subparagraphs 14-404(a)(3)(ii) (committing of unprofessional conduct in the practice of medicine), 14-404(a)(11) (willfully making or filing a false report or record in the practice of medicine, and 14-404(a)(43) (except for the licensure process described under Subtitle 3A of this title, violating 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).

PROPOSED FINDINGS OF FACT

Having considered testimony, demeanor evidence, and the exhibits in evidence, I find the following facts by a preponderance of the evidence:

Respondent's Professional Background

1. The Respondent's country of origin is Egypt. He completed his medical schooling at the University of Alexandria in Egypt and obtained his license as a general practitioner in Egypt. The Respondent practiced medicine in Egypt for approximately five to six years before coming to the United States in approximately 1991, initially settling in New Jersey, where his wife had family.

2. Between 1992 and 1995, the Respondent obtained certification from ECFMG[9] for licensure in the United States, and in 1995, he moved to Maryland to start a three-year residency program, having matched with Prince George's Hospital in Cheverly, Maryland.

3. After completing his residency, the Respondent was offered a position as a family practitioner at a primary care practice with five to six other doctors. He remained with that practice until approximately 2002, when he opened his own practice.

4. Since 2002, the Respondent has been a solo practitioner. He employs two medical assistants and a front desk employee. In his practice, the Respondent treats adults and children six years of age and older for a variety of ailments, including diabetes, depression, bipolar disease, anxiety, high cholesterol, heart disease, hypertension, orthopedics, and some gynecological issues. He sees approximately 25 patients a day and has a patient population of 4,000 to 5,000 individuals.

[9] The ECFMG is the Educational Commission for Foreign Medical Graduates. *See* COMAR 10.32.01.02B(11).

5. The Respondent received training in psychiatric disorders as part of his medical education and training in both Egypt and the United States, and he was tested on psychiatric disorders as part of his family practice board examination.

6. Approximately ten to fifteen percent of the Respondent's patient population is diagnosed with a psychiatric disorder. He prescribes psychotropic medication as part of his practice and refers patients to psychiatrists and counselors as needed.

7. The Respondent regularly treats patients for infections; he sees approximately five patients per day for acute infections.

8. The Respondent regularly prescribes antibiotics in the course of his practice.

9. The Respondent has not previously been disciplined by the Board.

Respondent's Treatment of [redacted]

10. [redacted] speaks Arabic as her native language and is not fluent in English. After moving to Maryland for the Respondent's medical residency program, [redacted] began to experience what the Respondent concluded were symptoms of [redacted]. She was consistently reluctant to seek treatment for her symptoms, due in part to the language barrier and to her discomfort in seeking treatment from others outside of her culture.

11. During the Respondent's psychiatric rotation of his residency, the attending physician, Dr. [redacted] spoke Arabic and he spoke with [redacted] to provide an informal medical consult. Dr. [redacted] agreed that [redacted] was experiencing [redacted] and he

suggested that she might benefit from [redacted] but cautioned the Respondent to be cognizant of the potential for side effects.[10]

12. Thereafter, beginning in approximately 1998, the Respondent began prescribing psychiatric medications for his wife and acting as her primary care physician.

13. Initially the Respondent prescribed his wife [redacted]. As a result, the Respondent changed his wife's medication to [redacted] which continued, so the Respondent increased her dose of [redacted] That dose was effective, and she continued with that dose.[11]

14. Throughout the time when he was treating her, the Respondent informally monitored [redacted] for side effects from the psychiatric medication, but he did not make and keep an ongoing record of his observations.

15. Over a course of years, the Respondent also prescribed [redacted] a Schedule IV CDS,[12] to [redacted] to treat [redacted]

16. In addition, at various times between May 2012 and December 2020, the Respondent prescribed the following medications for his wife: [redacted][13]

[10] [redacted]

[11] An attempt to wean her off the medication resulted in a return of her symptoms.

[12] Controlled Dangerous Substance

[13] Certain of the prescriptions [redacted] were originally prescribed by other doctors, and the Respondent later continued those prescriptions.

17. From May 2012 to June 2020, the Respondent prescribed [redacted] to [redacted] at least 33 times.

18. The Respondent did not keep and maintain regular records of his treatment of [redacted]. From approximately 1998 until 2020, the only medical record the Respondent made and kept for her was a November 10, 2017 pre-operative report that was required by her treating urologist in advance of a surgical procedure.

19. During the time when the Respondent was acting as [redacted] primary care physician, she saw a separate urologist, gynecologist, dermatologist, and eye doctor.

20. The Respondent continued to prescribe medications, including psychiatric medications, for [redacted] and to act as her primary care physician until sometime in the second half of 2020, after he received the Board's subpoena and spoke with his attorney. The Respondent and [redacted] have since found a primary care doctor from whom she is comfortable receiving care. The Respondent no longer treats [redacted] or prescribes medications to her.

Respondent's Prescribing for [redacted]

21. Around the time when the Respondent prescribed [redacted] for [redacted] [redacted] visited them from Egypt for several months. At the Respondent's suggestion, [redacted] tried some of [redacted] prescription to see if it would help her [redacted]

22. The Respondent evaluated [redacted] by taking a history of her symptoms and treatment before suggesting she try [redacted] prescription.

23. The Respondent did not make and keep any record of this evaluation of [redacted]

24. After returning to Egypt, the [redacted] requested and was prescribed [redacted] by her own healthcare provider; over time, she concluded that the version available in Egypt was not as effective as the version of [redacted] available in the United States.

25. In approximately 2013, as a result of [redacted] dissatisfaction with the medication available in Egypt, the Respondent began prescribing [redacted] in [redacted]'s name with the intention of sending it to [redacted] for her use.

26. [redacted] would fill the prescription at a local pharmacy and the prescription would be billed through [redacted]'s insurance; then a friend or community member who was traveling to Egypt would carry the prescription to [redacted] in Egypt.

27. The Respondent continued writing the prescription for [redacted] in [redacted]'s name but for [redacted]'s use until 2020, when he was contacted by the Board. He no longer prescribes medication for [redacted] either directly or indirectly.

28. The Respondent did not perform periodic examinations of [redacted] or keep any medical records for [redacted] during the time when he was prescribing [redacted] for her use.

29. The Respondent did not consult with [redacted]'s treating rheumatologist during the time when he was prescribing [redacted] for her use.

30. [redacted]'s pharmacy records and her November 2017 pre-operative medical report reflect the [redacted] prescriptions, thereby indicating that she was taking [redacted] when she was not.

The Ethical Prohibition on Treating Family Members

31. In May 2012, the AMA Council on Ethical and Judicial Affairs published Opinion 8.19, *AMA Code of Medical Ethics' Opinion on Physicians Treating Family Members*, in the AMA Journal of Ethics (AMA Opinion 8.19). The opinion remained available via the AMA Journal of Ethics' website. (State Ex. 9.)

32. AMA Opinion 8.19 states that "Physicians generally should not treat themselves or members of their immediate families." (State Ex. 9 at 1.) It explains that treatment of family members raises concerns about professional objectivity; the physician's willingness to inquire into sensitive matters relevant to treatment and the patient's willingness to reveal such information; the potential for family tensions to impact the professional relationship; the potential for treatment to be rendered beyond the physician's area of expertise or training; and patient autonomy and informed consent.

33. AMA Opinion 8.19 allows that treatment of immediate family members would not be inappropriate in emergency situations or where there is no other qualified physician available. It further notes that physicians should not act as a primary care provider for immediate family members and that providing routine care to a family member is only acceptable for "short-term, minor problems." (State Ex. 9 at 1.)

34. AMA Opinion 8.19 further states, "Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for . . . immediate family members." (State Ex. 9 at 1.)

35. In its winter 2012 newsletter, the Board included a write-up publicizing AMA Opinion 8.19. In the write-up, the Board further noted that it was permitted to use the AMA code of ethics in its disciplinary proceedings. The Board also observed that Maryland courts had

recognized "an ethical bar to the treatment of family members" except in isolated situations. (Jt. Ex. 1.)

36. The AMA reiterated the ethical limitations on the treatment of immediate family members in its Code of Medical Ethics Opinion 1.2.1, which was published in or about 2016 and was available via the AMA's website.[14] (State Ex. 10.)

37. The Board has taken disciplinary action against physicians who provided regular medical treatment to family members. Its disciplinary actions are reflected in public documents, available on the Board's website.

38. For instance, on June 3, 2020, the Board found Ralph B. Epstein, M.D., "guilty of unprofessional conduct in the practice of medicine . . . for providing medical treatment to his family members . . . ." (State Ex. 13 at 000266.) The Board's disciplinary decision in that case is a public document, available on its website.

39. Similarly, on June 19, 2020, the Board entered into a Consent Order with Peter G. Uggowitzer, M.D., in which the Board concluded that he was guilty of unprofessional conduct in the practice of medicine for treating two family members for several years and for self-prescribing CDS. (*See* Resp. Ex. 6.)

40. Within the Respondent's country of origin, physicians do treat family members.

DISCUSSION

Applicable Law

In order to protect the health, safety, and welfare of the public, the Maryland Legislature has charged the Board with regulating physicians licensed to practice in Maryland. Health Occ.

[14] The exhibit does not contain a publication date and the website information printed on the bottom of the exhibit does not indicate the date it was printed. However, the Statement of Charges identifies the opinion as being from 2016, and there was no contention to the contrary.

§§ 1-102, 14-205. Among its duties, the Board is responsible for overseeing licensing, investigating complaints, and disciplining physicians. Health Occ., §§ 14-205, 14-401. The Board's disciplinary powers include reprimanding a physician, placing a physician on probation, or suspending or revoking a physician's license. *Id.* § 14-404. The grounds on which the Board may take such disciplinary action include, as relevant here, unprofessional conduct in the practice of medicine; willfully making or filing a false report or record in the practice of medicine; and violating any provision of the Maryland Medical Practices Act,[15] any rule or regulation adopted by the Board, or any State or federal law pertaining to the practice of medicine. *Id.* § 14-404(a)(3)(ii), (11), (43). The Board's disciplinary authority is subject to the physician's right to a hearing prior to imposition of the disciplinary action. *Id.* §§ 14-404(a), 14-405(a).

Neither the Maryland Medical Practices Act nor the regulations governing disciplinary and licensing proceedings before the Board specifically set out and allocate the burden of proof at a hearing on disciplinary charges. When not otherwise provided by statute or regulation, the standard of proof in a contested case hearing before the OAH is a preponderance of the evidence, and the burden of proof rests on the party making an assertion or a claim. Md. Code Ann., State Gov't § 10-217 (2021); *Comm'r of Labor and Indus. v. Bethlehem Steel Corp.*, 344 Md. 17, 34 (1996) (*citing Bernstein v. Real Estate Comm'n*, 221 Md. 221, 231 (1959)); COMAR 28.02.01.21K. Accordingly, the State bears the burden of proving the alleged charges against the Respondent. That is, the State must show that it is "more likely so than not," when all the evidence is considered, that the Respondent committed the violations with which he is charged. *Coleman v. Anne Arundel Cty. Police Dep't*, 369 Md. 108, 125 n.16 (2002).

[15] *See* Health Occ. § 14-701.

For the reasons set forth below, I find that the State has satisfied its burden of proof.

Unprofessional Conduct in the Practice of Medicine

The charges brought against the Respondent assert that by providing treatment to [redacted] and [redacted], by failing to maintain records or progress notes for the treatment he provided to them, and by failing to periodically examine [redacted], the Respondent committed unprofessional conduct in the practice of medicine. (Charges, ¶ 12.) Section 14-404 of the Health Occupations Article authorizes disciplinary action against a licensed physician who "[i]s guilty of . . . [u]nprofessional conduct in the practice of medicine." Health Occ. § 14-404(a)(3)(ii).

1. Unprofessionalism and the Treatment of Family Members.

At the hearing, the parties spent a considerable amount of time addressing the ethics of treating family members. The Respondent acknowledged that he was required to follow the professional standards set by the Board but maintained that he was not specifically aware of a prohibition on providing regular medical care to immediate family members. He further explained that the opposite was true in Egypt (that family-member physicians were viewed as a source of trusted care) and that the prohibition on treating family members had not been covered during his training in the United States.

The statute does not define what constitutes "unprofessional conduct." The Court of Appeals of Maryland in addressing subsection 14-404(a)(3) of the Maryland Medical Practices Act has explained:

> The term refers to conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession. *Shea v. Bd. of Medical Exam'rs,* 81 Cal.App.3d 564, 146 Cal. Rptr. 653, 660 (1978). *See also Pietsch v. Minnesota Bd. of Chiropractic Exam'rs,* 662 N.W.2d 917, 923-24 (Minn. App. 2003) ("unprofessional conduct" is, of itself, a

> sufficiently definite ground upon which a board may revoke a license even in the absence of regulations defining what constitutes "unprofessional conduct")[.]

Finucan v. Bd. of Physicians, 380 Md. 577, 593 (2004). What constitutes "unprofessional conduct" is "determined by the 'common judgment' of the profession as found by the professional licensing board." *Id.* To this end, the applicable regulations provide that the Board may consider the AMA's principles of ethics. COMAR 10.32.02.16.

As of at least May 2012, the AMA established, explained, and published its stance on the ethics of treating family members.

> Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member . . . is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. . . . When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, . . . such difficulties may be carried over into the family member's personal relationship with the physician.
>
> Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. . . . Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.
>
> It would not always be inappropriate to undertake . . . treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat . . . family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not

> appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

(State Ex. 9; *see also* State Ex. 10.)

The Board publicized this ethical prohibition in its winter 2012 newsletter, in which it advised licensees: of the AMA's stance on the ethics of treating family members; that the Board was permitted to use the AMA's code of ethics in its disciplinary proceedings; and that the Maryland courts had recognized this prohibition as far back as 2004, citing *Finucan*, 380 Md. at 599 n.6. (Jt. Ex. 1.) In addition, the Board has previously disciplined physicians for treating and prescribing to family members; its orders in those cases are public documents available on the Board's website. (*See, e.g.*, Resp. Ex. 6; State Ex. 13.) Dr. [redacted]s testimony established that prior to this, as early as approximately 1996, the ethical concerns of treating family members were addressed by the Board in a video ("Crossing a Line") that was required viewing for newly licensed physicians and for established physicians when they were next relicensed.

The testimony of the Respondent's own expert witness, Dr. [redacted] also supports the conclusion that the prohibition on treating family members was commonly known within the profession. In this regard, during examination about the Respondent's prescription of [redacted] to [redacted] Dr. [redacted] was asked if he was aware of the AMA ethics opinions cited by the Board. Dr. [redacted] responded that he was not aware of the specific opinions prior to being retained in connection with this proceeding, but clarified that nonetheless, "I of course knew that one doesn't prescribe for one's family." The State's expert, Dr. [redacted], likewise testified that she was aware, since her residency (1986-1989), that it was unprofessional to treat family members; she noted that doctors routinely refer family members to other physicians. She also explained that it is a physician's responsibility to inform themself of the applicable ethical standards.

The AMA's adoption and publication of its stance against physicians treating family members, the Board's recognition of that stance, its history of discipline against physicians for treating family members, and Dr. [redacted]'s and Dr. [redacted]'s recognition of the prohibition establish that the statutory prohibition against unprofessional conduct was commonly understood by licensed physicians to prohibit treatment of family members. As the Court of Appeals noted in *Finucan*, this was sufficient to advise licensed physicians that providing long-term, non-emergency treatment and prescriptions to family members was unprofessional and prohibited. *See* 380 Md. at 593; *see also Mesbahi v. Bd. of Physicians*, 201 Md. App. 315, 337-38 (2011) ("A physician is likewise presumed to know the laws regulating the practice of medicine[.]"). Whether the Respondent, himself, had actual knowledge of the AMA opinions or the ethical prohibition is not relevant to whether he is guilty of unprofessional conduct in the practice of medicine.

2. The Respondent's Care of [redacted].

The Respondent acknowledged acting as [redacted]'s primary care physician from approximately 1998 to 2020; he acknowledged prescribing her [redacted] various other medications for chronic and acute conditions. This was not short-term care, emergency treatment, or care rendered only until another provider became available.[16] The Respondent testified that over the years he suggested [redacted] see another doctor, but that she was not comfortable with that due to the language barrier and cultural differences and that, for a period of time, it would have meant he had to take time off of work to drive her, as she did not

[16] In addition to prescribing psychiatric medications for a long-standing condition, the records reflect that the Respondent was providing other non-emergency care to [redacted]. For instance, he ordered x-rays of [redacted] (State Ex. 6 at 00049.) The Respondent ordered bloodwork to diagnose and treat [redacted] prescribed her medication for [redacted] (*Id.* at 00050, 00053.) The Respondent sent [redacted] for screening [redacted] (*Id.* at 00051.) Additionally, he performed her pre-operative physical in November 2017 and sent her for routine lab work. (*Id.* at 00052-53.)

have a license. The Respondent asserted that if he did not provide care to [redacted] she would have forgone the care she needed.

I reject this as a justification for the Respondent acting as [redacted]'s primary care physician for over twenty years. The evidence established that [redacted] saw other medical providers when needed, including a urologist, a gynecologist, a dermatologist, and an eye doctor. Indeed, she initially saw the dermatologist without even informing the Respondent. [redacted] also agreed to speak with Dr. [redacted] so that he could consult with the Respondent about her mental health. The Respondent and [redacted] are within a reasonable distance of a populated area with a plethora of medical providers. While [redacted] may have been reluctant to see a provider other than the Respondent, the evidence establishes that she did so when necessary. It was up to the Respondent, as Dr. [redacted] explained, to establish the appropriate boundaries.

Moreover, the care the Respondent provided to [redacted] raised some of the ethical concerns identified by the AMA. For instance, she initially failed to disclose to the Respondent that she saw a dermatologist for [redacted] and was prescribed medication for that condition, illustrating concerns with patient candor. (State Ex. 6 at 00053.) The Respondent provided psychiatric care to [redacted] which is plainly a sensitive area that raises concerns of objectivity. The Respondent acknowledged that it was difficult for him to set boundaries with [redacted] due to concerns as to how she would react.

In addition, the Respondent failed to meet professional standards by failing to maintain records of his treatment. During her testimony, Dr. [redacted] knowledgeably explained the need for accurate and ongoing medical records; the records ensure a thoughtful process, they remind the physician of the patient's history and the care previously provided, and they ensure an informed

and orderly transfer of a patient's care. The Respondent provided care to [redacted] on an informal basis, treating her at home and not in his medical office. (*See, e.g.*, State Ex. 6 at 00054 [redacted] and 00055 ("[S]o what's the purpose of a medical record because I know everything about her more than she knows maybe . . . .").) Despite acting as her primary care physician for decades and prescribing medications, including Schedule IV CDS (meaning it had a potential for abuse or dependency), the Respondent failed to contemporaneously document the treatment provided or ensure continuity of care.[17] The problems with failing to maintain contemporaneous medical records is apparent in the November 2017 pre-operative report prepared by the Respondent, which omitted her diagnoses for [redacted] (*See* State Ex. 4A at 00012-14.)

3. The Respondent's Care of [redacted]

Additionally, the Respondent regularly prescribed [redacted] for use by [redacted] for a chronic condition [redacted]. He advised the Board of this during the course of its investigation, and he acknowledged this at the hearing as well. (*See, e.g.*, State Ex. 4 at 0009; State Ex. 6 at 00056-58.) The Respondent prescribed for [redacted] from approximately 2013 to 2020, even though [redacted] had her own rheumatologist in her home country. In prescribing medication for [redacted] the Respondent was regularly treating her; this was not emergency care, short term care, or care rendered only until another provider became available. As discussed above, providing ongoing, routine treatment for an immediate family member is contrary to the ethical standards to which physicians are held. (State Ex. 9; State Ex. 10.) The Respondent's behavior exemplified the concern that the family relationship may impact objectivity and the level of care provided: he did not make periodic examinations of [redacted]

[17] In addition, although the Respondent sent [redacted] for lab work over the years, he did not maintain the results of those tests. (State Ex. 6 at 00053.)

[redacted] who he saw in person only every three to four years, or maintain any medical records for [redacted] he did not speak with [redacted]'s treating doctor during the time he prescribed medications for her, despite stating that he relied on the expertise of the treating doctor; instead, he depended on [redacted] to update him on the care her treating doctor was providing. Further, the Respondent obtained the medication by writing the prescription in [redacted]'s name, and he then ferried the prescription medication to [redacted] by relying on various third parties who, by happenstance, were traveling to Egypt. *See* discussion, *infra*, p. 22.

4. The Respondent is Guilty of Unprofessional Conduct in the Practice of Medicine.

The Respondent's conduct—acting as [redacted]'s primary care physician for decades and regularly prescribing medication for [redacted]'s use, but in [redacted]'s name—was unethical. Failure to abide by recognized ethical standards constitutes unprofessionalism. *Finucan*, 380 Md. at 593. It is apparent that his conduct was within the practice of medicine. Health Occ., § 14-101(o) (defining "practice medicine" to include diagnosing, treating, preventing or prescribing for any physical, mental, or emotional ailment, with or without compensation); *see also Finucan*, 380 Md. at 596-97 (giving broad interpretation to "in the practice of medicine" as used within section 14-404).

The Respondent also failed to make and keep medical records for either [redacted] or [redacted] and he did not periodically examine [redacted]; he explained that he talked to her about her treatment and saw her in person when she came to visit every three to four years. As explained by Dr. [redacted], this is contrary to the standards of professionalism expected of physicians. Again, it is apparent that this was within the practice of medicine. Health Occ., § 14-101(o).

Accordingly, the Respondent is guilty of unprofessional conduct in the practice of medicine, as charged. Health Occ. § 14-404(a)(3)(ii).

Willfully Making or Filing a False Report or Record in the Practice of Medicine

The Respondent is also charged with violating the Maryland Medical Practices Act by willfully making or filing a false report or record in the practice of medicine. (Charges, ¶ 12.) Such conduct is in violation of subsection 14-404(a)(11) of the Health Occupations Article. The charge is based on the Respondent's practice of writing prescriptions in [redacted]'s name for a medication intended for [redacted]'s use. The Respondent admitted to this practice during the Board's investigation, in order to explain to the Board why he was prescribing two similar medications for [redacted]. (State Ex. 4 at 0009; State Ex. 6 at 00056-58.) The Respondent's testimony at the hearing was in accord. Further, on cross-examination, the Respondent expressly acknowledged that he made untrue statements in the prescription and that he did so knowingly, willingly, and voluntarily.

The Respondent explained that he was trying to help [redacted] obtain the medication from the United States and that writing the prescription in [redacted]s name was the only way he could think of to get the medication for [redacted]. Whether the Respondent had a malicious motive or a compassionate one is irrelevant at this point in the analysis. *See Kim v. Bd. of Physicians*, 423 Md. 523, 544 (2011).

At the hearing, the Respondent described the process by which he obtained the medication for [redacted] Although he could not say with certainty that the prescription was consequently billed through [redacted]'s insurance, he ultimately conceded that "most likely it went through the insurance." Further, as a result of this scheme, the pre-operative report that the

Respondent prepared for [redacted]'s surgery incorrectly reflected that she was taking [redacted] the Respondent credibly explained that the inclusion of [redacted] in this report was accidental.

The evidence plainly establishes that the Respondent knowingly, intentionally, and repeatedly made a false statement in a record by writing prescriptions for [redacted] in [redacted]'s name with the intention that the medication be used by [redacted] Prescribing constitutes the practice of medicine. Health Occ. § 14-101(o)(2)(i). Accordingly, the Respondent willfully made a false report or record in the practice of medicine. Health Occ. § 14-404(a)(11).

Violation of a provision of the Maryland Medical Practices Act, a Board Rule or Regulation, or a State or Federal Law Pertaining to the Practice of Medicine

The statement of the charges against the Respondent includes a charge for violating subsection 14-404(a)(43), which provides:

> (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:
>
> . . .
>
> (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[.]

The statement of charges does not set out any independent factual or legal basis for the alleged violation of 14-404(a)(43). (Charges, ¶¶ 12 & 13.) The same conduct alleged to be in violation of subsections 14-404(a)(3) and (11) forms the basis for this charge. (*Id.*) Although there is no separate and independent basis for this charge, the above violations technically constitute a violation of subsection 14-404(a)(43).

Sanctions

The purpose of imposing sanctions under section 14-404 of the Maryland Medical Practices Act is not to punish, but rather to protect. As the Court of Appeals of Maryland explained in *McDonnell v. Comm'n on Medical Discipline*:

> The purpose of disciplinary proceedings against licensed professionals is not to punish the offender but rather as a catharsis for the profession and a prophylactic for the public. *See Maryland St. Bar Ass'n v. Agnew*, 271 Md. 543, 318 A.2d 811 (1974); *Bar Ass'n v. Marshall*, 269 Md. 510, 307 A.2d 677 (1973). *See also Unnamed Physician v. Comm'n*, 285 Md. 1, 400 A.2d 396 (1979), *quoting In re Kindschi*, 52 Wash.2d 8, 319 P.2d 824 (1958).

301 Md. 426, 436 (1984) (emphasis added).

With this purpose in mind, the Board is authorized to reprimand a physician, place the physician on probation, or suspend or revoke a physician's license for a violation of section 14-404 of the Maryland Medical Practices Act. Health Occ. § 14-404(a); COMAR 10.32.02.09A. Instead of or in addition to a disciplinary sanction, the Board may assess a fine against a licensee. Health Occ. § 14-404(d)(1); COMAR 10.32.02.09A(3)(d). The Board may also include rehabilitative conditions as a part of the sanction. Health Occ. §14-404(e); COMAR 10.32.02.09A(5).

The Board has promulgated a sanctioning matrix to guide it in the consideration of the appropriate sanction and any fine. COMAR 10.32.02.10; *see also* COMAR 10.32.02.09. Upon consideration of aggravating and mitigating factors, the sanction ultimately imposed by the Board may depart from the guidelines. COMAR 10.32.02.09A(8), (9), B.

Under the guidelines, the sanction for a physician who is guilty of unprofessional conduct in the practice of medicine, consisting of non-sexual ethical violations, ranges from a minimum sanction of a reprimand to a maximum sanction of revocation. The fine ranges from a minimum of $5,000.00 to a maximum or $50,000.00. For a physician who willfully makes or files a false

report or record in the practice of medicine the sanction ranges from a minimum of a reprimand to a maximum of revocation; the fine ranges from $10,000.00 to $50,000.00. Unsurprisingly, there is no range of sanctions or fines specified for violation of subsection 14-404(a)(43), a flexible category that could encompass a broad array of offenses.[18]

Here, the State recommends the imposition of a 30-day suspension of the Respondent's license to practice in Maryland, followed by a term of two years of probation with the conditions that the Respondent (1) pay a fine of $15,000.00 and (2) enroll in and complete, within six months, courses in medical record keeping and medical ethics. The Respondent, on the other hand, advocates for a sanction that is at the bottom of, or even below, the range specified in the Board's sanctioning guidelines and argues that suspension of his license would be an undue hardship and that any suspension would result in the withdrawal of his board certification.

Although sanctions serve the purpose of protecting the public, by their very nature, sanctions have a punitive aspect from the licensee's perspective. *See McDonnell*, 301 Md. at 436. The applicable regulation sets out aggravating and mitigating factors to be considered; mere amelioration of the punitive effect is not a mitigating factor for consideration. COMAR 10.32.02.09B(5), (6). Thus, even though he has tried to frame it as a matter impacting patient care, I reject the Respondent's argument that the punitive impact of the sanction warrants mitigation.

[18] As noted, the Board has specified the maximum and minimum sanctions and fines for violations of 14-404(a)(3) and (11) and also provided for a departure from those ranges where there are mitigating or aggravating circumstances. COMAR 10.32.02.09A(8), (9). In light of that, there would be no reason to enlarge the sanction based on an entirely duplicative charge for violating subsection 14-404(a)(43), without more. Imposing a separate or additional sanction for violating subsection 14-404(a)(43) would, in this case, seem to be needlessly punitive and duplicative and contrary to the Board's own sanctions guidelines. *See also* COMAR 10.32.02.09A(6).

Nonetheless, there are several significant mitigating factors. Pertinent here, the Respondent has no prior history of being disciplined, he cooperated with the Board's investigation, and his examination under oath reveals he made a full disclosure during the Board's investigation, as he did at the hearing. Indeed, he disclosed that he began treating [redacted] much earlier than the available records establish. I also note that the Respondent was not motivated by any financial considerations, and there was no evidence of nefarious intent in his treatment of [redacted]. As a result of the investigation, the Respondent ceased prescribing to [redacted] and he worked with [redacted] to find a primary care physician with whom she was comfortable and prepared a summary of [redacted]'s care for the physician (Dr. [redacted].

I credited the Respondent's explanation that he was unaware of the ethical prohibition on the treatment of family members and that it was normal for physicians to do so in Egypt. He explained that, in Egypt, family-member physicians were viewed as very trustworthy sources of care. In crediting the Respondent's testimony, I noted that he answered questions frankly and thoroughly, and his tone, demeanor, and manner of responding did not appear deceptive or evasive. Further, the Respondent's testimony was consistent with his statements to the board nearly a year earlier. Even prior to that, there was no evidence that during the decades in which he acted as her primary physician, the Respondent tried to hide his treatment of [redacted]—the Respondent asked Dr. [redacted] for a consult for [redacted] and Dr. [redacted] then recommended treatment options; the Respondent prepared and sent a pre-operative report to [redacted]'s urologist. His actions were consistent with an unknowing violation. While his ignorance of the accepted standards does not excuse the Respondent's violation, it bears on his culpability and

potential for rehabilitation and explains the extended period of time over which he treated [redacted]

In contrast, however, the Respondent willfully created false records in connection with the [redacted] prescription intended for [redacted]'s use but written in [redacted]'s name. The Respondent explained that he felt pressured to help because he knew [redacted] was suffering and he did not want to refuse [redacted]'s request that he assist [redacted] Again, I found the Respondent to be credible in his contention that he was motivated by a desire to assist [redacted] and appease [redacted] Nonetheless, his action was clearly willful. The Respondent had to have recognized, at the time, that intentionally writing the prescription in [redacted]'s name and soliciting others to unofficially carry the medication across national borders to [redacted] for her use was contrary to accepted standards and unprofessional. Nonetheless, he continued this practice for many years. That he felt pressured to do so illustrates the very reason for the ethical prohibition on treating immediate family members.

The lack of medical records for [redacted] and [redacted] and the failure to examine his [redacted] while prescribing [redacted] for her over the course of years certainly created the potential for injury. Dr. [redacted] persuasively identified and explained the concerns for potential injury raised by the Respondent's violations of the Maryland Medical Practices Act, including over prescribing antibiotics, disclosure and informed consent issues, and the potential for interruption of or tampering with the [redacted] being sent to [redacted]

Having noted that there was the potential for injury, it bears noting that there was no evidence that any actual injury occurred. The State pointed to the lack of medical records to raise questions in this regard. Despite the lack of documentation that might reflect any injury, the Respondent was clearly motivated by a desire to aid his family members and acted within his

scope of practice. The Respondent testified that he regularly treats and prescribes for patients with mental health disorders and was trained and tested on this area.[19] He also noted that [redacted]'s new doctor had not changed her medications. The Respondent observed that [redacted]'s doctor was continuing to monitor her in Egypt throughout the entire time, that he periodically spoke with [redacted] to see how she was progressing, and that there had been no supply or tampering issues in connection with the [redacted] being transported to [redacted]

I cannot say the Respondent's conduct was isolated, as it occurred over the course of years and decades, though it was not conduct that more broadly impacted his patient population. Furthermore, based on the Respondent's testimony, his cooperation with the Board, his cessation of the practices at issue, and his demeanor, I am confident that the Respondent is unlikely to resume these practices.

Significantly, the Respondent exhibited rehabilitative potential at the hearing. Although he emphasized the distinction in the practice in the United States versus Egypt and his concern that his wife would not seek treatment if he did not provide it, this was offered by way of explanation for his past actions, and not by way of continued denial. The Respondent explained that he had never been advised of the ethical concerns raised by treating family members and stated that as a sole practitioner, he had not previously had the time to educate himself on such considerations. He expressly stated that he now understood that the treatment was inappropriate. He was firm and direct in his testimony that he would never again treat a family member and agreed that he violated the ethical prohibition in his treatment of [redacted] and [redacted]

[19] Although the State questioned the Respondent about [redacted]

The State argues that the Respondent lacked "insight into the fact that his actions were dishonest and fraudulent." (State's Closing at 10.) It points to the Respondent's answer to a question about whether he had caused a financial loss to the insurance company by virtue of the Cymbalta prescriptions being billed through [redacted]'s insurance. I disagree with the State's argument. Given the context of that particular question, it elicited a response refuting that, on whole, the insurance company sustained an actual monetary loss because of the Respondent's practices. I can infer nothing further from the Respondent's answer; he acknowledged his actions throughout the hearing and throughout the investigation and his testimony made clear that he now thoroughly understood that his actions were wrong. He agreed that he made a false statement in prescribing the [redacted] for [redacted]'s use. He was contrite, though explanatory, in his testimony; he now clearly understood that he had violated the ethical standards of the profession, and expressly stated as much.

The Respondent asked that for guidance I look to the sanctions that were imposed by Consent Order in Board Case No. 2219-0200B, *In re Peter G. Uggowitzer, M.D.* In that case, a physician prescribed CDS to himself and two family members and admitted that he had acted as one family member's primary care physician for approximately 10 years and had prescribed CDS for that family member for "several years." The medical records the physician maintained for that family member lacked the relevant diagnosis and symptoms. The physician was given a reprimand, placed on one year of probation, and required to pay a $1,000.00 fine, and complete an ethics course within six months. (Resp. Ex. 6.) The Respondent asserts that this case is much different than *In re Ralph B. Epstein, M.D.*, Board Case Number 2218-0269, in which the physician (who practiced in obstetrics and gynecology) treated three family members dating back nearly two decades; twice, he performed elective surgery on a family member; he prescribed a

schedule II CDS repeatedly to one family member (39 times in 18 months), and in disregard of red flags concerning the individual's use of the CDS; he provided treatment both inside and outside of his area of practice; and he had been disciplined by the Board four times previously. (State Ex. 13.) The Board revoked the physician's license and imposed a fine of $50,000.

The Respondent's case is nowhere near as egregious as the case of Dr. Epstein. While in many respects it is similar to that of Dr. Uggowitzer, the Respondent here has the added dimension of willfully falsifying a report or record in the practice of medicine, a very serious consideration. Plainly, each disciplinary proceeding, including the case at hand, turns on a host of facts particular to that matter.

The Respondent requests consideration of a downward departure from the sanctioning guidelines. The balance of the mitigating factors is not so great as to warrant a downward departure from the minimum sanctioning guidelines set out in regulation. That said, the recommended sanction is well above the minimum guidelines and includes both a thirty-day suspension and a $15,000.00 fine. Taking into account the evidence presented and the mitigating and aggravating factors—including the patent willfulness with regard to the creation of a false record, but also the demonstrated potential for rehabilitation, the lack of prior discipline, and the clear unlikeliness of a recurrence—I find that the recommended sanction exceeds what is necessary to protect the profession and the public and would be excessively punitive in design.

Based on the charged violations and the aggravating and mitigating factors, I find that the evidence supports the disciplinary sanctions of a stayed suspension, provided that the Respondent take a Board-approved course in medical recordkeeping and a separate Board-approved course in medical ethics, both to be completed within six months of the Board's final decision; and that the Respondent complete a probationary period of two years, requiring

payment of a $10,000.00 fine within one year of the Board's final decision. Health Occ. § 14-404(a)(3), (11), (43), (d)(1), (e); COMAR 10.32.02.09A(3)(d), (4), (5).

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude as a matter of law that the Respondent violated the alleged provisions of the law. Md. Code Ann., Health Occ. § 14-404(a)(3), (11), (43) (2021). As a result, I conclude that the Respondent is subject to disciplinary sanctions of a stayed suspension, conditioned on the Respondent's completion of a course in medical record keeping and a course in medical ethics within six months of the Board's final decision, and a two-year probationary period, conditioned on payment of a $10,000.00 fine within one year of the Board's final decision. Health Occ. § 14-404(a)(3), (11), (43), (d)(1), (e); COMAR 10.32.02.09A(3)(d), (4), (5), B; COMAR 10.32.02.10B(3), (11).

PROPOSED DISPOSITION

I **PROPOSE** that charges filed by the Maryland State Board of Physicians against the Respondent on February 16, 2021 be **UPHELD**; and

I **PROPOSE** that the Respondent be sanctioned by a stayed suspension, conditioned on the completion, within six months, of a course in medical recordkeeping and a course in medical ethics, and a two-year probationary period, conditioned on payment within one year of a $10,000.00 fine.

[redacted]

January 4, 20221
Date Decision Issued

Emily Daneker
Administrative Law Judge

ED/cj
#195429

RIGHT TO FILE EXCEPTIONS

Any party adversely affected by this proposed decision may file written exceptions with the disciplinary panel of the Maryland State Board of Physicians that delegated the captioned case to the Office of Administrative Hearings and request a hearing on the exceptions. Md. Code Ann., State Gov't § 10-216(a) (2021); COMAR 10.32.02.05. Exceptions must be filed within fifteen (15) days of the date of issuance of this proposed order. COMAR 10.32.02.05B(1). The exceptions and request for hearing must be addressed to the Disciplinary Panel of the Board of Physicians, 4201 Patterson Avenue, Baltimore, MD, 21215-2299, Attn: Christine A. Farrelly, Executive Director. A copy of the exceptions should be mailed to the opposing attorney, and the other party will have fifteen (15) days from the filing of exceptions to file a written response addressed as above. *Id.* The disciplinary panel will issue a final order following the exceptions hearing or other formal panel proceedings. Md. Code Ann., State Gov't §§ 10-216, 10-221 (2021); COMAR 10.32.02.05C. The Office of Administrative Hearings is not a party to any review process.

Copies Mailed To:

Christine A. Farrelly, Executive Director
Compliance Administration
Maryland Board of Physicians
4201 Patterson Avenue
Baltimore, MD 21215

Robert Gilbert, Assistant Attorney General
Administrative Prosecutor
Health Occupations Prosecution and
Litigation Division
Office of the Attorney General
300 West Preston Street, Suite 207
Baltimore, MD 21201

Rosalind Spellman, Administrative Officer
Health Occupations Prosecution and
Litigation Division
Office of the Attorney General
300 West Preston Street, Room 201
Baltimore, MD 21201

David J. McManus, Esquire
Baxter, Baker, Sidle, Conn & Jones, PA
120 East Baltimore Street, Suite 2100
Baltimore, MD 21202

Diaa Y. Mikhail, MD
[redacted]

Nicholas Johansson, Principal Counsel
Health Occupations Prosecution and
Litigation Division
Office of the Attorney General
300 West Preston Street, Room 201
Baltimore, MD 21201