

IN THE MATTER OF

*

BEFORE THE

JAMES K. LIGHTFOOT, JR., M.D.

*

MARYLAND STATE

Respondent

*

BOARD OF PHYSICIANS

License Number: D52326

*

Case Number: 2218-0284

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FINAL DECISION AND ORDER

INTRODUCTION

On April 16, 2019, Disciplinary Panel A (“Panel A”) of the Maryland State Board of Physicians (“Board”) charged James K. Lightfoot, M.D. under the Maryland Medical Practice Act with being guilty of immoral and unprofessional conduct in the practice of medicine, in violation of Md. Code Ann., Health Occ. §14-404(a)(3)(i) and (3)(ii). The case was forwarded to the Office of Administrative Hearings (“OAH”) for an evidentiary hearing on the charges.

An evidentiary hearing was held at OAH on January 7, 2020. On March 27, 2020, the Administrative Law Judge (“ALJ”) issued a proposed decision concluding that Dr. Lightfoot is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. §14-404(a)(3)(ii). The ALJ did not uphold the charge that Dr. Lightfoot was guilty of immoral conduct in the practice of medicine, in violation of Health Occ. §14-404(a)(3)(i). The ALJ recommended a sanction of a reprimand, probation, and a fine of \$10,000.00.

On April 13, 2020, the State filed exceptions to the ALJ’s proposed decision. On May 4, 2020, Dr. Lightfoot filed a response to the State’s exceptions. On May 6, 2020, the State filed a Motion to Strike Respondent’s response and requested that the Panel strike subheading D of Dr. Lightfoot’s response, which contained references to the confidential settlement discussions that occurred at the Disciplinary Committee for Case Resolution (“DCCR”) Conference before Panel A. *See* COMAR 10.32.02.03E(9)(c). On May 15, 2020, Dr. Lightfoot submitted an amended

response to the State's exceptions, which removed the portions of subheading D that referenced the confidential DCCR proceedings. Dr. Lightfoot requested that the Panel accept the amended response without making any further redactions and find that the Motion to Strike is moot given that the subject matter and content objected to in the State's Motion to Strike has now been removed from the Panel's consideration. On June 5, 2020, the chair of Board Disciplinary Panel B ("Panel B" or "the Panel") issued an Order accepting the amended response, striking the original response, and declaring that the State's Motion to Strike was moot. On June 24, 2020, both parties appeared before Panel B for an exceptions hearing.

FINDINGS OF FACT

Neither party challenged any of the ALJ's proposed findings of fact. Panel B adopts the ALJ's proposed and stipulated findings of fact, numbers 1-39. *See* ALJ proposed decision, attached as **Exhibit 1**. The findings of fact are incorporated by reference into the body of this document as if set forth in full. The findings of fact were proven by a preponderance of the evidence. A summary of the facts is as follows:

Dr. Lightfoot was licensed by the Board to practice medicine on July 8, 1997. At the time of the facts in this case, Dr. Lightfoot worked at a hospital in Maryland and was typically the only doctor on staff during overnight shifts. On seven occasions between December of 2015 and December of 2017, Dr. Lightfoot provided treatment and prescribed medications, including Controlled Dangerous Substances ("CDS"), to a patient ("Patient 1")¹ with whom he had a close personal and financial relationship.

Dr. Lightfoot met Patient 1 at a bar in 2009 and the two became friends and exchanged phone numbers. Dr. Lightfoot and Patient 1 engaged in a romantic and sexual relationship and dated for a year and a half to two years. The relationship ended and Dr. Lightfoot did not hear

¹ The patient is referred to as Patient 1 to protect the patient's privacy.

from Patient 1 again until 2013 when she reached out to Dr. Lightfoot for help because she was pregnant with someone else's child and had no place to live. Dr. Lightfoot agreed to have Patient 1 move in with him during and after her pregnancy, when her parents no longer allowed her to live at their house. The sexual relationship resumed for a short period of time, but after it ended Patient 1 and Dr. Lightfoot remained friends. Dr. Lightfoot allowed Patient 1 to live at his house and after she moved out, he paid approximately \$3,500 per month for Patient 1's rent and living expenses, including child support and car insurance, and paid over \$40,000 for Patient 1's drug treatment rehabilitation, which continued after their sexual relationship ended, but during the time when Dr. Lightfoot treated Patient 1 in the Emergency Department.

Between 2015 and 2017, after the sexual relationship ended, but during the time when Dr. Lightfoot continued to provide financial support to Patient 1, Dr. Lightfoot treated and prescribed medications, including CDS, to Patient 1 on seven occasions in the emergency room and prescribed medications to Patient 1 on four occasions outside of the emergency room. Finally, in December of 2017, Dr. Lightfoot recognized a pattern in Patient 1's behavior where she would come to see him in the emergency department every few months when she was in between programs and he told Patient 1 not to come to the emergency room again when he was working.

EXCEPTIONS

The ALJ found that Dr. Lightfoot was guilty of unprofessional conduct in the practice of medicine when he prescribed medications, including CDS, outside of the emergency department without keeping a medical record, and when he prescribed CDS in the emergency department on seven occasions in the context of an emotionally and financially complex, close personal relationship. The ALJ did not find that the actual medical care Dr. Lightfoot provided to Patient 1 in the emergency department, including the prescriptions for CDS, was unprofessional and the ALJ did not find that Dr. Lightfoot was guilty of immoral conduct in the practice of medicine.

Neither party disputes nor takes exception to the ALJ's finding that Dr. Lightfoot was guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii). The State took exception to the ALJ's finding that the actual care Dr. Lightfoot provided to Patient 1 did not constitute unprofessional conduct in the practice of medicine. The State also took exception to the ALJ's finding that Dr. Lightfoot was not guilty of immoral conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(i).

The quality of the actual medical treatment Dr. Lightfoot provided to Patient 1 is not at issue in this case, as Dr. Lightfoot was not charged with a standard of care violation, in violation of Health Occ. § 14-404(a)(22). The Panel, therefore, does not make any findings regarding the quality of the substantive medical care Dr. Lightfoot provided to Patient 1. Accordingly, the Panel need not address the qualifications of the experts or the expert opinions as they relate to the substantive medical care Dr. Lightfoot provided to Patient 1.

Rather, the Panel's focus is on the boundary issues and compromised objectivity involved in treating and prescribing medications, especially CDS, to a family member or close friend. Dr. Lightfoot's lengthy and undisputed relationship with Patient 1 included a prior sexual and romantic relationship and ongoing financial support including paying at least \$40,000.00 for Patient 1's drug addiction treatment and paying \$3,500.00 per month for Patient 1's living expenses. Patient 1 also lived with Dr. Lightfoot for periods of time and Dr. Lightfoot was well aware of Patient 1's history of drug addiction. Dr. Lightfoot did not document his relationship with Patient 1 in the medical records nor did he inform anyone at the hospital of his relationship with Patient 1. It is also undisputed that Dr. Lightfoot prescribed medications to Patient 1 outside of the Emergency Department on four occasions and did not keep a medical record. Finally, on the dates when Patient 1 presented to the emergency department where Dr. Lightfoot was working, it is undisputed that Patient 1 drove over 40 minutes to go to the hospital where Dr. Lightfoot was working when

there were several hospitals closer to her home at which she could have received care and treatment.

By treating Patient 1 and prescribing medications to her, including prescriptions for CDS, Dr. Lightfoot compromised his objectivity and allowed his personal relationship with Patient 1 and concerns about her potential relapse to compromise his professional judgment and decision-making ability. Dr. Lightfoot admitted that he knew that prescribing CDS to family members and friends was frowned upon, yet he ignored his better judgment and treated Patient 1, not once, but seven times at the hospital, and prescribed CDS to Patient 1 on four occasions outside of the hospital. Dr. Lightfoot is guilty of unprofessional conduct in the practice of medicine.

The State argues that the ALJ erroneously relied on a narrowly construed concept of immoral conduct in reaching the conclusion that Dr. Lightfoot was not guilty of immoral conduct in the practice of medicine. The ALJ found that because the care Dr. Lightfoot provided to Patient 1 was professional, there was no evidence that he exploited Patient 1 and, therefore, the ALJ did not find that Dr. Lightfoot's conduct was immoral. As discussed above, the Panel does not make any findings regarding the care Dr. Lightfoot provided to Patient 1. While the Panel disagrees with the ALJ's reasoning, the Panel does not find that Dr. Lightfoot is guilty of immoral conduct in the practice of medicine in this case.

CONCLUSION OF LAW

Based on the foregoing Findings of Fact, Panel B concludes as a matter of law that Dr. Lightfoot is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii). The charge under Health Occ. § 14-404(a)(3)(i) is dismissed.

SANCTION

The ALJ recommended a sanction of a reprimand, probation, and a fine of \$10,000.00. The ALJ did not recommend a length of time for the probation or any conditions of probation. The

State took exception to the ALJ's proposed sanction and asked the Panel to impose a sanction of a reprimand, thirty-day suspension, eighteen months of probation with enrollment in the Maryland Professional Rehabilitation Program, and a \$10,000.00 fine. Dr. Lightfoot responds that the Panel should adopt the sanction proposed by the ALJ and argues that any period of suspension is excessive and unwarranted.

The Panel recognizes, as the ALJ did, that Dr. Lightfoot's boundary violation was limited to a single patient, but it was by no means an isolated incident. Dr. Lightfoot treated and prescribed medications to Patient 1, including CDS, on seven occasions in the Emergency Department and on four occasions outside of the emergency department. After the seventh time that Patient 1 showed up to the emergency department, Dr. Lightfoot recognized there was a pattern involved in Patient 1 seeking prescriptions from him. The Panel agrees with the ALJ that Dr. Lightfoot exhibited serious lapses in professionalism in this case and that his conduct can be remediated. The Panel also agrees with the State that a brief period of suspension is warranted in this case to demonstrate the importance of maintaining professional boundaries. The Panel, therefore, will impose a 5-day suspension followed by a period of probation with a referral to the Maryland Professional Rehabilitation Program and a course in professional boundaries. The Panel will also impose a civil fine of \$10,000.

ORDER

It is, on the affirmative vote of a majority of the quorum of Disciplinary Panel B, hereby

ORDERED that James K. Lightfoot, M.D. is **REPRIMANDED**; and it is further

ORDERED that Dr. Lightfoot's license to practice medicine in Maryland, license number D52326, is **SUSPENDED**² for **FIVE (5) BUSINESS DAYS** starting the day after the effective

² (a) During the suspension period, Dr. Lightfoot shall not:
(1) practice medicine;

date of this Order. After five (5) business days have passed, Dr. Lightfoot's suspension will be administratively terminated through an order of the disciplinary panel; and it is further

ORDERED that upon termination of the suspension, Dr. Lightfoot is placed on **PROBATION**³ for a minimum period of **ONE (1) YEAR**. During the probationary period, Dr. Lightfoot shall comply with the following probationary terms and conditions:

(1) Dr. Lightfoot shall enroll in the Maryland Professional Rehabilitation Program (MPRP) as follows:

- (a) Within 5 business days, Dr. Lightfoot shall contact MPRP to schedule an initial consultation for enrollment;
- (b) Within 15 business days, Dr. Lightfoot shall enter into a Participant Rehabilitation Agreement and Participant Rehabilitation Plan with MPRP;
- (c) Dr. Lightfoot shall fully and timely cooperate and comply with all MPRP's referrals, rules, and requirements, including, but not limited to, the terms and conditions of the Participant Rehabilitation Agreement(s) and Participant Rehabilitation Plan(s) entered with MPRP, and shall fully participate and comply with all therapy, treatment, evaluations, and screenings as directed by MPRP;
- (d) Dr. Lightfoot shall sign and update the written release/consent forms requested by the Board and MPRP, including release/consent forms to authorize MPRP to make verbal and written disclosures to the Board and to authorize the Board to disclose relevant information from MPRP records and files in a public order. Dr. Lightfoot shall not withdraw his release/consent;
- (e) Dr. Lightfoot shall also sign any written release/consent forms to authorize MPRP to exchange with (i.e., disclose to and receive from) outside entities (including all of Dr. Lightfoot's current therapists and treatment providers) verbal and written information concerning Dr. Lightfoot and to ensure that MPRP is authorized to receive the medical records of the Respondent,

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- (2) take any actions after the effective date of this Order to hold himself out to the public as a current provider of medical services;
 - (3) authorize, allow or condone the use of Dr. Lightfoot's name or provider number by any health care practice or any other licensee or health care provider;
 - (4) function as a peer reviewer for the Board or for any hospital or other medical care facility in the state;
 - (5) prescribe or dispense medications; or
 - (6) perform any other act that requires an active medical license.

³ If Dr. Lightfoot's license expires during the period of probation, the probation and any conditions will be tolled.

including, but not limited to, mental health and drug or alcohol evaluation and treatment records. Dr. Lightfoot shall not withdraw his release/consent;

- (f) Dr. Lightfoot's failure to comply with any of the above terms or conditions including terms or conditions of the Participant Rehabilitation Agreement(s) or Participant Rehabilitation Plan(s) constitutes a violation of this Order;

(2) Within **SIX (6) MONTHS**, Dr. Lightfoot is required to take and successfully complete a course in professional boundaries. The following terms apply:

- (a) It is Dr. Lightfoot's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the course before the course is begun;
- (b) The disciplinary panel will not accept a course taken over the internet;
- (c) Dr. Lightfoot must provide documentation to the disciplinary panel that he has successfully completed the course;
- (d) The course may not be used to fulfill the continuing medical education credits required for license renewal;
- (e) Dr. Lightfoot is responsible for the cost of the course;

(3) Within **ONE (1) YEAR**, Dr. Lightfoot shall pay a civil fine of \$10,000.00. 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. Lightfoot's license if Dr. Lightfoot fails to timely pay the fine to the Board; and it is further

ORDERED that Dr. Lightfoot shall not apply for early termination of probation; and it is further

ORDERED that, after Dr. Lightfoot has complied with all terms and conditions of probation and the minimum period of probation imposed by this Order has passed, Dr. Lightfoot 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. Lightfoot may be required to appear before the disciplinary panel to discuss his petition for termination. The

disciplinary panel may grant the petition to terminate the probation, through an order of the disciplinary panel, if Dr. Lightfoot 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, if Dr. Lightfoot allegedly fails to comply with any term or condition imposed by this Order, Dr. Lightfoot 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. Lightfoot 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. Lightfoot has failed to comply with any term or condition imposed by this Order, the disciplinary panel may reprimand Dr. Lightfoot, place Dr. Lightfoot on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke Dr. Lightfoot's license to practice medicine in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on Dr. Lightfoot; and it is further

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

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

Signature on File

08/17/2020
Date

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, Dr. Lightfoot has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within thirty (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. Lightfoot files a Petition for Judicial Review, the Board is a party and should be served with the court's process at the following address:

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

Notice of any Petition for Judicial Review should also be sent to the Board's counsel at the following address:

**Stacey M. Darin, Assistant Attorney General
Office of the Attorney General
Maryland Department of Health
300 West Preston Street, Suite 302
Baltimore, Maryland 21201**

Exhibit 1

MARYLAND STATE BOARD OF
PHYSICIANS

v.

JAMES K. LIGHTFOOT, JR.,
RESPONDENT
LICENSE No.: D52326

* BEFORE JENNIFER L. GRESOCK,
* AN ADMINISTRATIVE LAW JUDGE
* OF THE MARYLAND OFFICE
* OF ADMINISTRATIVE HEARINGS
* OAH No.: MDH-MBP2-71-19-25914

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PROPOSED DECISION

STATEMENT OF THE CASE
ISSUES

SUMMARY OF THE EVIDENCE
PROPOSED AND STIPULATED FINDINGS OF FACT
DISCUSSION

PROPOSED CONCLUSIONS OF LAW
PROPOSED DISPOSITION

STATEMENT OF THE CASE

On April 16, 2019, a disciplinary panel of the Maryland State Board of Physicians (Board) issued charges against James K. Lightfoot, Jr. (Respondent), alleging violations of State law governing the practice of medicine. Md. Code Ann., Health Occ. §§ 14-101 through 14-508, and 14-601 through 14-607 (2014 & Supp. 2019). Specifically, the Board charged the Respondent with violating sections 14-404(a)(3)(i) (immoral conduct in the practice of medicine) and 4-404(a)(3)(ii) (unprofessional conduct in the practice of medicine) (Supp. 2019); Code of Maryland Regulations (COMAR) 10.32.02.03E(3)(d). The disciplinary panel forwarded the charges to the Office of the Attorney General for prosecution, and another disciplinary panel delegated the matter to the Office of Administrative Hearings (OAH) for issuance of proposed findings of fact, proposed conclusions of law, and proposed disposition. COMAR 10.32.02.03E(5); COMAR 10.32.02.04B(1).

I held a hearing on January 7, 2020, at the OAH in Hunt Valley, Maryland. Health Occ. § 14-405(a) (Supp. 2019); COMAR 10.32.02.04. Christopher J. Greaney, Esquire, represented the Respondent, who was present. Kelly Cooper, Assistant Attorney General and Administrative Prosecutor, represented the State of Maryland (State). Michael Kao, Assistant Attorney General, was present on behalf of the Board.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules for Hearings Before the Board, and the Rules of Procedure of the OAH. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2014 & Supp. 2019); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

1. Is the Respondent guilty of unprofessional conduct in the practice of medicine?
2. Is the Respondent guilty of immoral conduct in the practice of medicine?
3. What sanctions, if any, are appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following exhibits into evidence on behalf of the Board:

Bd. Ex. 1 - Licensing Information

Bd. Ex. 2 - Complaint, received April 23, 2018

Bd. Ex. 3 - Medical Records for [REDACTED] from [REDACTED], dated December 2, 2015; March 29, 2016; April 6-7, 2016; July 21, 2016; November 30, 2016; April 5, 2017; and December 13, 2017

Bd. Ex. 4 - Medical Records for [REDACTED] from the Respondent, dated December 2, 2015; March 29, 2016; April 7, 2016; July 21, 2016; November 30, 2016; April 5, 2017; and December 13, 2017

¹ [REDACTED] full name appears throughout the record in this case. However, as her identity is not germane to the substance of my proposed facts, analysis, conclusions of law, or proposed disposition, and her medical care is discussed in detail in this case, I have used only her initials in this proposed decision to protect her privacy.

- Bd. Ex. 5 - Prescriptions for [REDACTED] written by the Respondent, received from CVS Pharmacy, dated September 1, 2015 and February 23, 2017
- Bd. Ex. 6 - Prescriptions for [REDACTED] written by the Respondent, received from Giant Pharmacy, dated October 28, 2015 and January 13, 2016
- Bd. Ex. 7 - Respondent's written response, dated October 26, 2018
- Bd. Ex. 8 - Interview Transcript, dated January 17, 2019
- Bd. Ex. 9 - Documents received from the Respondent during his interview, various dates
- Bd. Ex. 10 - Documents regarding financial payments by the Respondent for [REDACTED], received from the Respondent, February 13, 2019
- Bd. Ex. 11 - Report of Investigation, dated March 19, 2019
- Bd. Ex. 12 - Charges Under the Maryland Medical Malpractice Act, dated April 6, 2019
- Bd. Ex. 13 - CV of [REDACTED], FACP, FACOFP
- Bd. Ex. 14 - Letter from [REDACTED] to Christine A. Farrelly, Executive Director, dated September 13, 2019

I admitted the following exhibits into evidence on behalf of the Respondent, except as noted:

- Resp. Ex. 1 - CV of the Respondent
- Resp. Ex. 2 - CV of [REDACTED], MD, MPH, CPPS, FACEP
- Resp. Ex. 3 - Amended Expert Report of [REDACTED], dated October 30, 2019
- Resp. Ex. 4 - Statement from [REDACTED], undated
- Resp. Ex. 5 - Financial documents, various dates
- Resp. Ex. 6 - NOT ADMITTED
- Resp. Ex. 7 - NOT OFFERED
- Resp. Ex. 8 - Letter, [REDACTED], dated October 22, 2019
- Resp. Ex. 9 - Letter, [REDACTED], dated October 22, 2019

Testimony

The following witnesses testified on behalf of the Board:

- Troy Garland, Compliance Analyst, Maryland Board of Physicians; and
- [REDACTED], accepted as an expert in general medicine and medical ethics.

The Respondent testified in his own behalf, and presented the following witness:

- [REDACTED], accepted as an expert in emergency medicine and addiction medicine.

PROPOSED AND STIPULATED FINDINGS OF FACT²

Having considered all of the evidence presented, I find the following facts by a preponderance of the evidence:

1. At all times relevant to this proceeding, the Respondent was, and is, a physician licensed to practice medicine in the state of Maryland. The Respondent was initially licensed to practice on or about July 8, 1997, and his license is currently scheduled to expire on September 30, 2020.³
2. The Respondent is Board-certified in Emergency Medicine. At all times relevant to these charges, he was employed by a staffing agency, [REDACTED], P.A./P.C. ([REDACTED])⁴ and assigned to the emergency department.⁵
3. For approximately sixteen years, the Respondent has worked the overnight shift in the emergency department at [REDACTED] in Takoma Park, Maryland. He is typically the only doctor on staff overnight.

² The parties stipulated to some facts in this case. I have included all stipulated facts that I determined to be relevant to the proceeding, with some minor edits for clarity and relevance. I did not separate the stipulated facts from my findings of fact in order to preserve the overall narrative of the case but have indicated via footnotes which facts were stipulations.

³ Stipulated fact.

⁴ [REDACTED] is managed by Altheon Health.

⁵ Stipulated fact.

4. Sometime in 2009, the Respondent met [REDACTED] at a bar⁶ and the two became friends, meeting periodically for lunch or dinner.

5. At that time, the Respondent was living in Silver Spring, Maryland, and [REDACTED] was living in Virginia.

6. [REDACTED] has struggled with heroin addiction throughout the time that the Respondent has known her.

7. Sometime in 2011, the Respondent and [REDACTED] began a romantic relationship that lasted about eighteen to twenty-four months. They saw each other every four to six weeks because of the geographic distance between them.

8. The Respondent and [REDACTED] ended their relationship in 2013 and were no longer in contact for a period of time.

9. Later in 2013, [REDACTED] called the Respondent and told him that she was pregnant with someone else's child and needed help. He allowed her to move in with him for several weeks.

10. [REDACTED] then moved back in with her family and prematurely gave birth to a son.

11. Since her son's birth, [REDACTED] has been involved in a prolonged and acrimonious custody battle with her parents.

12. [REDACTED] again moved in with the Respondent in 2013, and they resumed their romantic relationship at that time for about six to twelve months.

13. After their romantic relationship ended, [REDACTED] continued to live in the Respondent's home, where she had her own bed, until sometime in 2015. The Respondent and [REDACTED] were no longer sexually intimate after their romantic relationship ended.

14. Sometime in 2015, [REDACTED] moved out of the Respondent's home to live with a boyfriend for about a year.

⁶ That the Respondent met [REDACTED] around this time is a stipulated fact.

15. [REDACTED] then moved back into the Respondent's home briefly before she began renting an apartment in Leesburg, Virginia in November 2016. The Respondent paid [REDACTED]'s rent and utilities when she first leased the apartment and has continued to do so since then.

16. The Respondent has also paid for [REDACTED]'s living expenses, including child support, groceries, clothing, car insurance, and cell phone. In total, the Respondent pays about \$3,500.00 per month for [REDACTED]'s expenses and has done so since she first leased her apartment in fall 2016.

17. The Respondent has paid for [REDACTED]'s treatment in at least eight outpatient addiction programs,⁷ totaling over \$40,000.00, since he first met her in 2009.

18. The Respondent and [REDACTED] remain friends at the present time. The Respondent talks to [REDACTED] every week and sees her once or twice per month.⁸

19. [REDACTED] has never worked for the Respondent in any capacity to earn money.⁹

20. On seven different occasions, [REDACTED] sought care in the emergency department at [REDACTED]. The Respondent was the only physician on duty and provided care to [REDACTED] each time, including a physical examination and prescribing medications. The dates of these emergency department visits are as follows: December 2, 2015; March 29, 2016; April 7, 2016; July 21, 2016; November 30, 2016; April 5, 2017; and December 13, 2017.¹⁰

21. The Respondent did not disclose his prior romantic or sexual relationship with [REDACTED] in the medical records for any of these visits.

22. When the Respondent treated [REDACTED] at the hospital, neither the hospital administration nor the staff members were aware of his past or current relationship with [REDACTED].¹¹

⁷ Stipulated fact.

⁸ Stipulated fact.

⁹ Stipulated fact.

¹⁰ The dates of these emergency department visits, the medications prescribed, the dosages, the quantities, and the lack of refills are stipulated facts.

¹¹ Stipulated fact.

23. Gabapentin (brand name Neurontin) is an anticonvulsant used to treat neuropathic pain.¹²

24. tramadol is a Schedule IV¹³ controlled dangerous substance and is a narcotic-like pain reliever.¹⁴

25. methadone is a Schedule II controlled dangerous substance and narcotic (opiate base) used to treat narcotic addiction (such as heroin or morphine addiction),¹⁵ as well as moderate to severe pain.

26. Before 2018, the policy of the Respondent's employer, [REDACTED], was that no more than twenty-five methadone pills should be prescribed at one time. In 2018, the guidelines were revised to limit the total number of methadone pills prescribed to fifteen.

27. Klonopin (generic name clonazepam), a benzodiazepine, is a Schedule IV controlled dangerous substance.¹⁶ It is used to treat seizures and anxiety.

28. Dexedrine is a Schedule II controlled dangerous substance and is a central nervous system stimulant.¹⁷ It is used to treat attention deficit hyperactive disorder (ADHD).

29. Chronic pain is defined by pain that has lasted three months.

30. On December 2, 2015, [REDACTED] presented at the emergency department with abdominal pain. She complained of nausea and vomiting over the prior two days. She had a history of chronic pain and had developed an opioid dependence. The Respondent determined that her symptoms were due to opioid withdrawal. He conducted a physical examination and

¹² The drug name and use are stipulated facts.

¹³ The federal Drug Enforcement Administration categorizes controlled dangerous substances into five schedules, with Schedule I representing the highest level of control and Schedule V representing the least.

¹⁴ Stipulated fact.

¹⁵ The drug name and use in treating narcotic addiction is a stipulated fact.

¹⁶ Stipulated fact.

¹⁷ Stipulated fact.

prescribed gabapentin for pain (300 mg oral capsules, ninety capsules, zero refills) and methadone (10 mg oral capsules, twenty-four tablets, zero refills).

31. On March 29, 2016, [REDACTED] presented at the emergency department with abdominal pain. She complained of anxiety, nausea, stomach pain, and cramping. [REDACTED] was physically examined and was prescribed gabapentin for pain (300 mg oral capsules, ninety capsules, zero refills) and methadone (10 mg oral capsules, twenty-four tablets, zero refills).

32. On April 7, 2016, [REDACTED] sought a refill of medication for ADHD, stating that she would not be able to see her primary care physician for two weeks. She was examined and was prescribed Dexedrine (15 mg capsules, twenty-eight tabs with zero refills).

33. On July 21, 2016, [REDACTED] presented at the emergency department with abdominal pain and skin irritation. She was examined and diagnosed with eczema and chronic pain with drug dependence. The Respondent prescribed hydrocortisone topical ointment, triamcinolone topical lotion, and methadone (10 mg oral capsules, twenty-four tablets, zero refills).

34. On November 30, 2016, [REDACTED] presented at the emergency department with pelvic and abdominal pain. She was examined and prescribed methadone (10 mg oral capsules, twenty-four tablets, zero refills).

35. On April 5, 2017, [REDACTED] presented at the emergency department with abdominal pain, which she stated she had experienced for three days prior. She was examined and diagnosed with chronic pain and drug dependence. She was prescribed methadone (10 mg oral capsules, twenty-four tablets, zero refills) and tramadol (50 mg 24-hour extended release capsules, twenty-four capsules, zero refills).

36. On December 13, 2017, [REDACTED] presented at the emergency department with anxiety and abdominal pain. She was diagnosed with situational anxiety and chronic pain. She was

prescribed Klonopin (1 mg, twenty tablets, zero refills) and tramadol (100 mg 24-hour extended release capsules, twenty-four capsules, zero refills).

37. On four occasions between September 1, 2015, and February 23, 2017, the Respondent prescribed the following medications for [REDACTED], outside of the emergency department and without a corresponding medical record:

- a. September 1, 2015: Pyridium (a pain reliever for the lower part of the urinary tract) (200 mg, fifteen capsules, no refills) and tramadol (50 mg, twenty-four capsules, no refills);
- b. October 28, 2015: tramadol (50 mg, twenty-four capsules, no refills);
- c. January 13, 2016: tramadol (50 mg, twenty-four capsules, no refills); and
- d. February 23, 2017: tramadol (50 mg, twenty-four capsules, no refills) and Neurontin (300 mg, sixty capsules, no refills).

38. The Respondent was aware that prescribing controlled dangerous substances to family and friends was "frowned upon."¹⁸

39. On or about April 23, 2018, the Board received a written complaint from [REDACTED]'s mother. The Complaint alleged the Respondent was providing financial support to [REDACTED] while [REDACTED] lived with the Respondent and that the Respondent was aware that [REDACTED] is addicted to heroin.

DISCUSSION

Legal Framework

The grounds for reprimand or probation of a licensee, or suspension or revocation of a license under the Act include the following:

- (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

¹⁸ Stipulated fact. The quotation is from an interview conducted with the Respondent in the course of the Board's investigation.

disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

(3) Is guilty of:

- (i) Immoral conduct in the practice of medicine; or
- (ii) Unprofessional conduct in the practice of medicine;

Health Occ. § 14-404(a)(3)(i) and (ii) (Supp. 2019).

Arguments of the Parties

The State contends that the Respondent's actions constitute unprofessional conduct in three specific ways: first, he provided medical care in the emergency department to a person with whom he had a close personal and financial relationship without disclosing that potential conflict of interest in the medical records; second, he prescribed controlled dangerous substances in excessive amounts and without an objective basis or adequate documentation while providing care in the emergency department; and third, he failed to properly document, on four occasions, prescriptions for controlled dangerous substances provided outside of the emergency department for that same friend. With regard to the friendship, the State cited a lengthy and undisputed relationship that included two periods during which the Respondent and [REDACTED] were romantically and sexually involved, as well as a long history of significant financial support totaling over \$90,000.00. In addition, the State contends that [REDACTED] lived with the Respondent at times, and he knew of her history of drug addiction. The State also maintains that the Respondent's actions were immoral, as he was not able to provide objective medical care that prioritized [REDACTED]'s best interests over her stated requests.

The Respondent does not dispute the facts as presented by the State. However, he argues that he has always acted with dedication and professionalism, and that he did the best he could in a difficult situation and in light of his knowledge of and professional experience with the challenges posed by drug addiction. He notes that there is no evidence that he exploited [REDACTED] in any way, failed to treat her in an appropriately objective manner, or that [REDACTED]'s medical care was

compromised by their personal or financial relationship. In fact, [REDACTED] is now doing well and credits, in part, the care provided by the Respondent. He also argues that I should consider that the complaint against the Respondent originated not with [REDACTED], but with her mother, who was angry about a custody matter she and her daughter were involved in. In other words, the complaint does not reflect any dissatisfaction on the part of the patient herself. Finally, the Respondent contends that since the investigation of this matter began, he has been open, honest, and straightforward about the nature of the relationship and the care that he provided.

Testimony

In support of its case, the State presented the testimony of Troy Garland, a compliance analyst with the Board, who received the complaint and investigated the matter. His investigation included an interview with the Respondent, as well as a review of the medical records, financial records reflecting the Respondent's support of [REDACTED], and the Respondent's written response to the complaint. When Mr. Garland interviewed the Respondent, he sought details about the care provided by the Respondent and the decisions he made in providing that care. For example, Mr. Garland asked the Respondent why he did not consult with [REDACTED]'s physicians or order a urinalysis to screen for illegal drugs before prescribing medications. The Respondent explained that he would have provided the same care regardless of the results of urinalysis, and that [REDACTED]'s physicians changed frequently, which would make consulting with them difficult. Mr. Garland also confirmed that the Respondent did not disclose his relationship with [REDACTED] to staff with whom he worked or in any medical record. Mr. Garland prepared a written report summarizing the facts he gathered in the course of his investigation.

The State also presented the testimony of [REDACTED], an expert in general medicine and medical ethics. [REDACTED] stated that, at the request of the Board, he reviewed this matter, including all medical records and the transcript of Mr. Garland's interview with the Respondent,

and concluded that the Respondent's actions constituted both unprofessional and immoral conduct.

With regard to unprofessional conduct, [REDACTED] cited the Respondent's failure to ensure objective treatment through laboratory tests and consultation with [REDACTED]'s doctors, improper documentation of prescriptions, improper documentation of the reason for prescribing controlled dangerous substances (i.e., pain management or addiction withdrawal), failure to disclose his relationship to [REDACTED] in medical documentation, and prescribing of an excessive number of methadone pills without appropriate tapering of dosage or the support of a methadone program. In [REDACTED]'s opinion, these factors, each of which he testified about in detail, prevented [REDACTED] from receiving optimal care.

More specifically, [REDACTED] testified that on each of the seven occasions when the Respondent treated [REDACTED] in the emergency department, a physical examination was conducted, but no laboratory tests, such as urinalysis, were done. [REDACTED] noted that such testing can be important to adequately verify a patient's subjective complaints of chronic pain and ensure that there was no other underlying medical condition. Additionally, the Respondent did not contact [REDACTED]'s medical providers before prescribing medication. Further, on four separate occasions outside of the emergency department, the Respondent prescribed medications for which he created no corresponding medical record; these prescriptions included tramadol, a controlled dangerous substance.

[REDACTED]'s most significant concerns in terms of unprofessional conduct related to the Respondent's prescriptions for methadone, which the Respondent prescribed in five of the seven emergency department visits. [REDACTED] explained that the Respondent should have made clear in the medical records why he was prescribing methadone. For example, if the Respondent was acting to fill gaps in treatment during times that [REDACTED] was not enrolled in an addiction program, he

should have noted this in the medical record. [REDACTED] also maintained that if the Respondent felt he had no choice but to treat [REDACTED] (rather than sending her to another hospital), he should have, at the very least, noted his personal relationship with her in the medical records so that the full context of any treatment he provided, including his potential conflict of interest, would be clear. However, even though the Respondent had a prior sexual relationship with [REDACTED] and an ongoing personal and financial relationship, he neither asked a colleague to provide care in his stead nor recorded the conflict of interest in any medical record.

[REDACTED] cited to American Medical Association (AMA) guidelines that advise against treating family members, but acknowledged that the guidelines do not address providing treatment to friends.¹⁹ He also referred to an AMA Journal of Ethics article from 2015 that discussed the challenges of remaining objective when treating a friend.²⁰ While [REDACTED] agreed that it may, on occasion, be difficult for an emergency department physician to avoid prescribing controlled dangerous substances for a friend, he maintained that in such cases the prescription should be for the shortest time possible. [REDACTED] explained that in his judgment, the number of medications prescribed (including four controlled dangerous substances: methadone, Dexedrine, tramadol, and Klonopin), and the number of methadone pills given, exceeded what was appropriate and therefore constituted unprofessional conduct, especially in the absence of a continuing plan of care or pain contract for methadone use.

[REDACTED] emphasized that as therapy for addiction, methadone should be prescribed within the context of an addiction program so that it can be appropriately monitored and tapered as needed. He noted that if the Respondent felt he had no other available options (such as referring the patient to another physician) and was concerned about the risk of overdose if he

¹⁹ These guidelines were not offered as evidence.

²⁰ The article was not offered as evidence, and [REDACTED] was unsure of the year it was published, stating that he "believe[d]" it was 2015.

turned [REDACTED] away, a prescription for methadone could be provided for a single day or weekend. Instead, the Respondent prescribed twelve days of methadone, well outside of the standard of care, according to [REDACTED] [REDACTED] referenced [REDACTED]'s Opioid Prescribing Guidelines from 2018, which state that when prescribing opioids, a physician should prescribe no more than fifteen tablets except in special clinical circumstances.²¹ The Respondent's failure to do this was unprofessional, according to [REDACTED]

[REDACTED] also addressed the Board's charge, with which he agreed, that the Respondent engaged in immoral conduct. [REDACTED] explained that the Respondent's failure to adequately verify [REDACTED]'s subjective symptoms and to provide care despite his own conflict of interest meant that the care the Respondent provided did not serve [REDACTED]'s best interests. [REDACTED] noted that it appears [REDACTED] went out of her way to seek care from the Respondent, bypassing hospitals that were far closer to her geographically, because she knew the Respondent would provide what she asked for, and that he would not objectively probe what course of action was most appropriate.

Additionally, according to [REDACTED], [REDACTED]'s relationship with the Respondent may have factored into what she was willing to disclose, which also could have compromised her treatment. In essence, contended [REDACTED], the Respondent's relationship with [REDACTED] breached boundaries that meant her care was not driven by an objective, science-based assessment of her medical needs.

[REDACTED], an expert in emergency medicine and addiction medicine, testified on behalf of the Respondent. [REDACTED] has extensive experience specifically in treating opioid use disorder. He also led the development of the [REDACTED] 2018 Opioid Prescribing Guidelines referenced by [REDACTED]. He noted that he was not paid to testify on the Respondent's behalf and has not socialized or worked directly with the Respondent, but felt compelled to testify for two reasons: first, because he contends that emergency medicine poses unique challenges that are

²¹ The guidelines are in evidence as Bd. Ex. 9.

not fully appreciated even within the medical profession, and second, because he knows the Respondent by reputation, and considers him to be an unusually professional, competent, dedicated, and well respected physician.

██████ testified that emergency department physicians treating individuals with addiction disorders must be particularly mindful of the need to reduce the risk of harm, and that decisions are driven by complex individual circumstances. Having reviewed the medical records in this case ██████ maintained that the Respondent's actions were consistent with an effort to reduce the risk of harm to ██████, noting that the risk of an overdose for a patient who is turned away from an emergency department without receiving methadone is significant. ██████ further testified that medical providers do not yet have an adequate model for successfully treating addiction, and that serious gaps in treatment place individuals with addiction disorders at risk. These individuals seek treatment in hospital emergency departments as a kind of last resort safety-net, and emergency department physicians must sometimes provide care, including methadone, outside of the context of an addiction program.

In ██████'s opinion, the prescriptions provided by the Respondent in the emergency department setting were appropriate and consistent with the standard of care. He noted that while ██████ suggested that a pain management contract with ██████ would have been appropriate and should have been in place, such a practice is impractical for emergency department physicians and is not the standard practice. ██████ also opined that laboratory testing is typically done in an emergency department setting only if such testing would have an impact on the course of treatment, that such testing takes significant time, and that urinalysis is not standard in an emergency department setting. Fentanyl, he noted, is not even detected by urinalysis. When asked about whether the Respondent's actions were unprofessional or immoral, he stated that in his opinion they were not, but he emphasized that he was testifying not

to establish adherence to a standard of care, but rather to provide perspective on the unique pressures faced by emergency department physicians and on what measures and practices are typical and practical. He agreed that the Respondent's conduct was suboptimal but stated that it was not unreasonable under the circumstances. [REDACTED] also noted that it is not unusual that an individual with an opioid addiction disorder would drive a long distance to a hospital for care, as there is significant stigma associated with drug addiction even among medical providers, and that those struggling to overcome addiction prioritize working with a medical provider they trust.

The Respondent testified on his own behalf, explaining the circumstances under which he met [REDACTED], the course of their romantic relationship and friendship, and his own motivation for providing her with emotional and financial support. He stated that he felt she had been dealt a short hand in life and had been shunned by her family, and that without support, she would have died due to her drug addiction. The Respondent did not contradict the facts as alleged by the State, and he expressed his regret for any shortcomings in the care he provided to [REDACTED]. However, he also provided some context for the choices he made and maintained that while he may not have adhered to best practices, he was not aware of any specific policies or guidelines that he violated.

The Respondent explained that he has been the sole physician on duty in the emergency department for the overnight shift for years, and that he encounters issues with drug addiction nearly every night. He noted that the first time [REDACTED] sought care in the emergency department during his shift, he considered whether it would be more appropriate for the physician's assistant on duty to provide care in his place. However, because he would need to sign off on the care provided regardless, he opted to provide care directly himself. He noted that when he prescribed methadone, the dosage was only 10 mg per day, and he knew that [REDACTED] had previously been prescribed as much as 80 mg per day. He acknowledged that the current recommendation, as

cited in the [REDACTED] 2018 Opioid Prescribing Guidelines, is not to prescribe more than fifteen tablets of methadone but stated that the prior recommendation – and the recommendation in place at the time he prescribed methadone for [REDACTED] – was twenty-five pills. He noted that his prescriptions did not exceed this recommendation.

More broadly, the Respondent explained that when [REDACTED] sought methadone in the emergency department, she was between addiction treatment programs, and that the gap between programs could be seven to ten days – more than enough time for a patient to experience withdrawal and overdose. He further explained that he has had professional experience with patients who overdosed after they were unable to obtain methadone in an emergency department setting, and that he is mindful of that experience, as well as the fact that addicts who have stopped using for a time are particularly vulnerable to the risk of overdose. The Respondent also testified that he did not order urinalysis for two reasons: first, he knew she would test positive for opioids, as she had recently been in an addiction program, and second, the outcome of testing would not alter the course of treatment.

The Respondent also explained his thinking with regard to the medications he prescribed, noting that tramadol is a short-acting pain reliever for breakthrough pain and that he prescribed Klonopin for anxiety because it is the safest medication in that class of drugs. As for the Dexedrine he prescribed for [REDACTED], a controlled dangerous substance typically taken in the morning and which [REDACTED] had singled out as particularly unnecessary in an emergency department setting, the Respondent testified that [REDACTED] would not be able to see her prescribing psychiatrist for the next two weeks. The Respondent noted that he did not consult with [REDACTED]'s doctors because they changed frequently and would have been difficult to reach in the middle of the night. He also stated that none of the prescriptions he wrote permitted refills, as he was mindful of limiting the number of doses he prescribed.

The Respondent further testified that he is not aware of any policy or guidelines that require disclosure of a personal relationship with a patient and emphasized that he was not romantically involved with [REDACTED] – and she was not living with him – at any of the times he treated her. In retrospect, he acknowledged that he understands that disclosure would have been wise. He also noted that the complaint against him did not originate with [REDACTED], but with her mother, with whom [REDACTED] had been involved in a heated custody dispute over her young son. Finally, he acknowledged that his conduct was not perfect, but maintained that he acted with the best of intentions, and that his only concern was the safety and well-being of his patient.

Analysis: Unprofessional Conduct and Immoral Conduct

Unprofessional Conduct

Based on the evidence before me, I am persuaded that the Respondent's actions constitute unprofessional conduct. Specifically, the Respondent prescribed medications, including controlled dangerous substances, outside of the emergency department without documenting the prescriptions in a corresponding medical record. In addition, on seven occasions, he prescribed controlled dangerous substances within the context of an emotionally and financially complex, close personal relationship that is not disclosed anywhere in the medical records.

That the Respondent prescribed medications on the four identified occasions – September 1, 2015; October 28, 2015; January 13, 2016; and February 23, 2017 – without documenting the prescriptions is uncontested. On each of the four occasions, these prescriptions included tramadol, a controlled dangerous substance. As [REDACTED] compellingly explained, without documentation, critical information, such as the diagnosis and the reason for the chosen treatment, are not captured, maintained, and available for use, and that without such documentation, the patient is prevented from receiving appropriate care.

It is also uncontested that on seven occasions – December 2, 2015; March 29, 2016; April 7, 2016; July 21, 2016; November 30, 2016; April 5, 2017, and December 13, 2017 – the Respondent prescribed controlled dangerous substances, including methadone, Dexedrine, tramadol, and Klonopin, without disclosure of his personal and financial relationship with [REDACTED] in the medical records. The Respondent explained that he was not aware of any requirement or recommendation for such disclosure, and [REDACTED] acknowledged that there are some gray zones with regard to the professional obligations associated with treating family and friends. Had the Respondent provided such treatment on a single occasion and failed to disclose the relationship, his conduct would be less concerning. However, in light of the seven visits over a two-year period, with controlled dangerous substances prescribed at each of the seven visits, the context of the Respondent's personal relationship with [REDACTED] is clearly relevant with regard to the treatment the Respondent provided, and I am persuaded by [REDACTED]'s expert opinion that it should have been disclosed.

Finally, I consider whether the Respondent's prescribing of controlled dangerous substances for the time periods prescribed constitutes unprofessional conduct. This includes the five prescriptions for methadone, each of which permitted twenty-four, or twelve days' worth, of pills; Dexedrine, prescribed for a two-week period (two pills per day), and typically prescribed for ADHD; and Klonopin, with twenty pills prescribed (a forty-day supply, as a dose is a half pill), typically prescribed for anxiety; and tramadol (twelve day supply), prescribed for pain.

As discussed above, [REDACTED]'s opinion regarding methadone was that a prescription should not exceed fifteen pills, or one week's worth. He noted that the Respondent failed to document the reason for the methadone (pain management versus addiction treatment). In addition, he testified that Dexedrine is an amphetamine and is a highly abused drug, and that it is usually taken once a day in the morning. The Respondent prescribed it around midnight, and he

did not complete any surveys, questionnaires, or other documentation for the diagnosis. [REDACTED]

[REDACTED] also stated that Klonopin is also a highly abused drug. With regard to the tramadol and gabapentin, [REDACTED] noted that these are sometimes prescribed for pain, but that a physician should typically order laboratory testing or imaging for objective confirmation of subjective symptoms and to identify the underlying cause of the pain, particularly when there is a history of drug dependence.

The Respondent addressed the concerns raised by [REDACTED] in his own testimony, explaining (as discussed above) that at the time he prescribed methadone, the guidelines permitted twenty-five pills, and that he did not exceed that amount. The Respondent also explained that laboratory testing is not always practical in an emergency department setting and that urinalysis results would not have changed the treatment. He also noted that gabapentin is not a controlled dangerous substance. He further explained that [REDACTED] would not be able to see her psychiatrist for a two-week period, which is why he prescribed Dexedrine for that period of time.

I note that [REDACTED]'s testimony had significant shortcomings that affect the weight that it is due on this issue. Specifically, [REDACTED] has limited experience in the practice of emergency medicine. He is not board-certified in emergency medicine and has never worked full time in an emergency department. For a number of years, he has worked only one clinical shift per week in an emergency department. In addition, he is not certified in addiction medicine or pain management and has relatively limited professional experience in this area.

On the other hand, I found [REDACTED]'s testimony highly persuasive on this issue. [REDACTED], who has extensive experience in opioid addiction disorder and is an expert in emergency medicine, explained the role that harm reduction plays in the judgment of an emergency department physician. It was his opinion that [REDACTED]'s presentation at the emergency department was consistent with significant risk to her health and well-being, and that it was reasonable for

the Respondent to conclude that her life was at risk. He noted that few options are available to emergency department physicians placed in that position. [REDACTED] also testified that the kind of pain management contract discussed by [REDACTED] is impractical in an emergency department setting and is not part of the standard of care. Similarly, he testified that laboratory tests and urinalysis are not typically done in an emergency department setting unless they would impact treatment, in part because the in-hospital testing technology is less reliable than having samples sent to a laboratory and because many substances are not detected by urinalysis. [REDACTED] also disputed [REDACTED]'s contention that the Respondent failed to adequately document the reason for prescribing methadone, noting that the medical records reflect both chronic pain and addiction issues, and that these are co-occurring disorders.

Accordingly, I am not persuaded that the Respondent's prescriptions for methadone exceeded recommendations in place at the time or required laboratory tests or urinalysis. Rather, the Respondent's prescriptions were a reasonable exercise of professional judgment under the circumstances, taking into account his experience in treating patients with addiction disorders in an emergency department setting. In addition, I conclude that the medical records adequately reflect the Respondent's reasons for prescribing methadone. As [REDACTED] testified, the Respondent documented both [REDACTED]'s addiction history and pain symptoms, and I find [REDACTED]'s testimony that the medical records are sufficient for care provided in an emergency department context. I further find that the Respondent's prescriptions for other controlled dangerous substances, including Dexedrine, Klonopin, and tramadol, were similarly reasonable. He credibly explained the basis for his decisions to prescribe these medications, and I found [REDACTED]'s testimony persuasive on this point.

Immoral Conduct

As discussed above, [REDACTED] testified that he was in agreement with the Board's conclusion that the Respondent's actions constitute immoral conduct. He explained it this way:

The immoral conduct was a summation of seven visits and the interview the Board had with the Respondent talking about supporting patients that he had cared for. And in the totality, I felt it was immoral and a breach of boundaries with these patients and that it would prevent them from getting the care they needed and prevent them from staying within the system. When people come to a physician they expect a science-based provider who has a specific way of treating them and while we feel we're doing that, seeing these visits I felt that they were getting care that they were requesting, potentially, or care that they wanted as opposed to what should have been done.

(Trans., p. 105.) [REDACTED] went on to testify that "the immoral [act] . . . was where he talked about supporting a homeless woman and her son. I thought those were some of the boundary breaches that had me concerned." (Trans., p. 108.)

I reviewed the transcript of the January 17, 2019 interview Mr. Garland conducted with the Respondent. (Bd. Ex. 23.) The Respondent was asked about people to whom he has provided financial support, other than [REDACTED]. He explained that he has several cousins to whom he provides support, and that he also provides some support for his father. He mentioned a friend who was involved in a car accident and to whom he provides support, as well as support he provides to another friend who had lost his job. He also stated that he provided support to a homeless mother and her daughter (not son, as stated by [REDACTED]). However, when asked if any of these individuals were ever his patients, his response was emphatic: "No, never."

Mr. Garland went on in the interview to ask about whether the Respondent had provided support to patients. The Respondent replied that he has provided Uber rides for patients when they needed a ride home and chipped in for clothing when it was needed. He described a homeless patient whose clothing was in shreds and said that he and one of the nurses purchased clothing for the man.

I have no reason to doubt the Respondent's contention that these relationships with individuals to whom he has provided support did not include any kind of physician/patient component at any time. No evidence in the record contradicts him. Since the Board began its investigation, he has been entirely forthcoming, honest, and sincere. His testimony before me was consistent with the information he provided to the Board during its investigation, and I found his testimony highly credible, both because of the consistency of his statements and the candor apparent in his demeanor. It is clear that [REDACTED]'s opinion regarding the Respondent's support for the homeless woman and her daughter was based on a faulty recollection of the Respondent's account. This significantly undermines [REDACTED]'s opinion that the Respondent's actions were immoral because of his "breach of boundaries . . . with patients," as [REDACTED] was relying on a factually inaccurate recollection of the Respondent's conduct.

[REDACTED]'s opinion that the Respondent's actions were immoral was also based on his interactions with [REDACTED]. [REDACTED] stated that "[i]mmoral is taking a person outside of what they would expect and facilitating behavior that's not in their best interest." While he acknowledged that no single interaction between the Respondent and [REDACTED] was in itself immoral conduct, he maintained that it was the totality of the incidents with her that led him to believe the Respondent's conduct was immoral.

I reviewed the case law cited by the parties regarding immoral conduct.²² Without exception, these cases involved explicit sexual exploitation of the physician/patient relationship, egregious sexual harassment of co-workers, or deliberate, self-interested dishonesty. A consistent theme of the

²² I reviewed the following cases: *Finucan v. Md. State Bd. Of Physician Quality Assur.*, 151 Md. App. 399 (2003) *aff'd*, 380 Md. 577 (2004); *Shirazi v. Md. State Bd. Of Physicians*, 199 Md. App. 469 (2011); *Banks v. Bd. Of Physician Quality Assur.*, 116 Md. App. 249 (1997), *aff'd*, 354 Md. 59 (1999); *Cornfeld v. State Bd. Of Physicians*, 174 Md. App. 456, *cert. denied*, 929 A.2d 890, 2007 Md. LEXIS 509 (Md. 2007); *Roane v. Md. Bd. Of Physicians*, 213 Md. App. 619 (2013). I also reviewed MBP Cohen 2001-0377, a Board decision dated July 14, 2006, and MBP Luperju 2016-0764A, a Consent Order issued April 13, 2018 (which addressed only unprofessional conduct).

case law is that the physicians' behavior in those cases was not only boundary-crossing, but also exploitive and damaging to patients. In addition, the Merriam-Webster Dictionary defines "immoral" as "conflicting with generally or traditionally held moral principles."²³ It defines "moral" as "of or relating to principles of right and wrong in behavior."²⁴

There is no evidence that the Respondent engaged in any exploitive behavior of any kind, with regard to [REDACTED] or any other patients. While [REDACTED] raised the possibility that the care the Respondent provided could have been compromised by his desire to provide [REDACTED] with what she asked for, rather than what she needed, there is no objective evidence that this, in fact, occurred, and the Respondent was able to credibly explain why he provided the care that he did. The patient herself never complained about the care she received, and while [REDACTED] maintained that this may be because she got whatever treatment she requested, the Respondent testified that [REDACTED] is doing well, and [REDACTED] herself submitted a statement expressing the same. (Resp. Ex. 4.) As discussed above, I have concluded that while the Respondent's actions fell short of his professional obligations with regard to disclosure of the relationship and adequate documentation of prescriptions, I did not find that the care itself was unprofessional or inappropriate in any way. Accordingly, I find that the State has not shown that the Respondent's actions were immoral.

Sanctions

The Board has stated that it seeks to impose the disciplinary sanctions of a reprimand, thirty-day suspension, and an eighteen-month probationary period that includes enrollment in a remediation program approved by the Board. Md. Code Ann., Health Occ. § 14-404(a) (Supp. 2019); COMAR 10.32.02.09; COMAR 10.32.02.10. Under the applicable law, the Board also may impose a fine instead of or in addition to disciplinary sanctions against a licensee who is found to

²³ Merriam-Webster Online Dictionary, 2020. <http://merriam-webster.com> (19 March 2020).

²⁴ *Id.*

have violated section 14-404. Health Occ. § 14-405.1(a) (2014); COMAR 10.32.02.09A(3)(d). The Board is also seeking a fine of \$10,000.00.

In light of my findings regarding unprofessional conduct due to the Respondent's failure to disclose the relationship and maintain adequate documentation of prescriptions, I agree that the reprimand and probationary period are appropriate.²⁵ I also agree that the \$10,000.00 fine is appropriate.²⁶ However, as I have concluded that the actual care the Respondent provided was not unprofessional, and that his conduct was not immoral, it is my recommendation that the Board not suspend the Respondent. While the Board clearly has the authority to impose such a suspension, there are significant mitigating factors in this case. The Respondent has no prior disciplinary history. Further, his errors with regard to disclosure and documentation appear to be confined to the care he provided to [REDACTED]; no evidence of a broader pattern was presented.

In addition, I note that the Respondent's employer, [REDACTED], responded to the Board's charges on his behalf, and that the response indicates, repeatedly, that the Respondent has engaged in a "critical self-assessment," has acknowledged that he "failed to consider the potential appearance of conflicts of interest in providing CDS prescriptions" to [REDACTED], is "remorseful" for his lapse in judgment, and is "committed, going forward, to exemplary practice concerning prescribing pain medication and meticulously avoiding even the potential appearance of a conflict of interest in treating all patients." (Bd. Ex. 7.) This is consistent with the Respondent's testimony before me; the Respondent's explanation for his actions was tempered by his acknowledgement that he could have done more to ensure that his actions were above reproach.

²⁵ Sanctioning guidelines provide that the maximum penalty for a violation of section 404(a)(3) of the Health Occupations Article is revocation and the minimum is a reprimand, for ethical violations that are not sexual in nature. COMAR 10.32.02.10B.

²⁶ Sanctioning guidelines provide a range of \$5,000.00 to \$50,000.00 for a fine. COMAR 10.32.02.10B(3)(c).

I also note that the record reflects that the Respondent is well-regarded by [REDACTED] and those with whom he has had professional contact. Martin Trpis, Esquire, deputy counsel for [REDACTED], provided a written response to the Board on behalf of the Respondent, and describes the Respondent's commitment to those he assists as "remarkable," noting that his "personality and proclivity to act altruistically to the degree that he does, is quite uncommon," and that his actions demonstrate his "integrity, conscience and beliefs." (Bd. Ex. 7.) The Respondent also submitted two letters, one from a social worker who worked with him in a Montgomery County program to provide outreach and treatment to addicts and one from a social worker who worked with him through the Montgomery County Crisis Center. Both praised his professionalism and competency without reservation. (Resp. Ex. 8 and 9.)

In short, the record makes clear that despite the serious lapses of professionalism in this case, the Respondent is a caring, compassionate physician, and my proposed disposition reflects this conclusion, without diminishing the importance of sanctions, including remediation through probation.

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude as a matter of law that the Respondent is guilty of unprofessional conduct, but not of immoral conduct. Md. Code Ann., Health Occ. § 14-404(a)(3)(i) and (ii) (Supp. 2018). As a result, I conclude that the Respondent is subject to disciplinary sanctions of a reprimand and probation for the cited violation. *Id.*; COMAR 10.32.02.09A(3).

I further conclude that the Respondent is subject to a fine of \$10,000.00 for the cited violation. Md. Code Ann., Health Occ. § 14-405.1(a) (2014); COMAR 10.32.02.09A(3)(d).

PROPOSED DISPOSITION

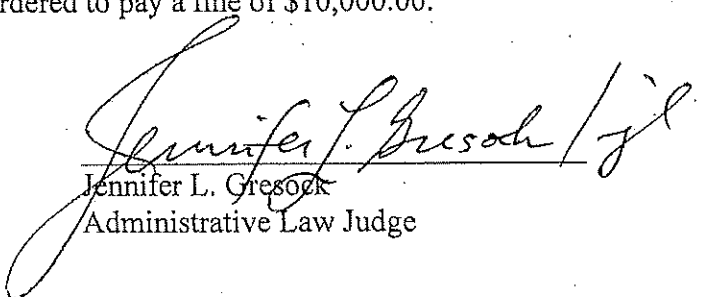
I **PROPOSE** that the charge filed by the Maryland State Board of Physicians against the Respondent on April 16, 2019, for unprofessional conduct be **UPHELD** and the charge filed for immoral conduct be **DISMISSED**; and

I **PROPOSE** that the Respondent be sanctioned by imposition of a reprimand and probation; and

I **PROPOSE** that the Respondent be ordered to pay a fine of \$10,000.00.

March 27, 2020
Date Decision Issued

JLG/dlm
#184649


Jennifer L. Gresock
Administrative Law Judge

NOTICE OF 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 (OAH) and request a hearing on the exceptions. Md. Code Ann., State Gov't § 10-216(a) (2014); 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 (2014); COMAR 10.32.02.05C. The OAH is not a party to any review process.