IN THE MATTER OF	*	BEFORE THE
MARCIA BENNETTE LOBRANO, M.D.	*	MARYLAND STATE BOARD
Respondent	*	OF PHYSICIANS
License Number: D53661	*	Case Number: 2218-0179

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FINAL DECISION AND ORDER

On August 2, 2019, Disciplinary Panel A of the Maryland State Board of Physicians (the "Board") charged Respondent Marcia Bennette LoBrano, M.D. with unprofessional conduct in the practice of medicine. *See* Md. Code Ann., Health Occ. § 14-404(a)(3)(ii). The case was forwarded to the Office of Administrative Hearings ("OAH") for an evidentiary hearing. A six-day evidentiary hearing was held before an Administrative Law Judge ("ALJ").

On May 15, 2020, the ALJ issued a Proposed Decision. The ALJ proposed that a panel of the Board conclude that the Respondent was guilty of unprofessional conduct in the practice of medicine, in violation of § 14-404(a)(3)(ii) of the Health Occupations Article. As a sanction, the ALJ recommended that the Respondent be reprimanded, be placed on probation for one year, enroll in the Maryland Professional Rehabilitation Program, and complete an intensive course on the management of health care professionals.

The Respondent filed exceptions, and, on July 15, 2020, an exceptions hearing was held before Board Disciplinary Panel B (the "Panel" or "Panel B").

FINDINGS OF FACT

Panel B finds the following facts were proven by the preponderance of evidence:

The Health Center[1]

1. The Health Center is a federally qualified health center ("FQHC") that provides primary medical care to low-income individuals who are on Medicare, Medicaid, or who lack health insurance.

2. The Health Center has multiple locations in Montgomery and Prince George's Counties, Maryland. The four highest-volume locations are Silver Spring, Takoma Park, Greenbelt, and Gaithersburg.

3. At the Takoma Park location, most of the patients and staff were Spanish-speaking.

4. At the highest-volume locations, providers saw about twenty patients daily. Providers were allocated fifteen to twenty minutes per patient visit.

5. The Health Center is reimbursed based upon the number of patient visits multiplied by a flat rate of reimbursement.

6. The Health Center's headquarters are in Silver Spring, and the executive staff work there.

7. At all times relevant to this matter, the Health Center served a total of approximately 62,000 patients.

8. Approximately 100,000 patient visits are handled by the Health Center each year.

9. The Board of Directors, as the governing body of the Health Center, was responsible for promulgation of policies and procedures. The Board of Directors handed down the policies and procedures to staff of the Health Center through the officers of the Health Center for implementation and enforcement. The Chief Medical Officer ("CMO"), Chief Operating

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[1] To protect the privacy of certain individuals, the names of certain health programs and individuals are often replaced with initials and generic terms. The "Health Center" is a generic name.

Officer ("COO"), and other executive-level staff were responsible for enforcing the Health Center policies and procedures.

10. The Health Center required employees with written contracts to contractually agree to abide by all policies and procedures. The Health Center required all at-will employees to agree, as a condition of employment, to abide by all policies and procedures.

11. Each Health Center location has a health center medical director ("HCMD") and a health center manager ("HCM"). The HCMD is a provider and is responsible for oversight of other providers at the location and reports to executive leadership. The HCM is not a provider and is responsible for oversight of staff at the location, scheduling, ensuring that the patient experience is good and also reports to executive leadership.

12. The HCMD and HCM work together closely to ensure that the location functions well. The HCMD, HCM, and the team nurse meet weekly to discuss any operational issues at the location. This is referred to as the Triad and was instituted by the Respondent.

13. The CMO at the Health Center has the responsibility for providing clinical leadership, fostering superior quality patient care, developing strategic goals and direction, and providing for the timely recruitment and retention of the medical staff. The CMO reports to the CEO and works collaboratively with the CEO and other senior leaders at the Health Center, including the COO and Chief Financial Officer ("CFO"). The CMO's functions and responsibilities include:

- Involvement in all initiatives and concerns involving patient safety and patient services, especially those related to provider issues;
- Leading provider productivity and taking action to improve productivity;
- Achieving and maintaining provider staffing goals;
- Supervising HCMDs and providing guidance and leadership for clinical flow; and

- Coordinating with program directors, senior leaders, and managers to provide clinical direction or recommendations for medical services-related programs.

14. HCMDs and HCMs are expected to communicate with the CMO regarding issues specific to their location.

15. All HCMDs would meet with the CMO once a month at the Silver Spring location of the Health Center.

16. The policy at the Health Center was that physicians were required to finish their charts between forty-eight and seventy-two hours after seeing a patient.

17. At least as of 2016, the Health Center had a policy related to the speaking of English in the workplace. There was no across-the-board prohibition against communication in Spanish or any other language at the Health Center. The policy was that English should be used in the workplace except where use of a foreign language was necessary to communicate with patients and family members for the provision of services.

18. The Health Center has a policy that it does not to write letters to courts hearing immigration cases.

19. The Health Center's hiring practices for health care professionals required recruitment and hiring of professionals who reflect the diversity of the Health Center patient population at the centers.

The Respondent

20. At all times relevant to this proceeding, the Respondent was licensed to practice medicine in Maryland. The Respondent has been licensed in Maryland since 1998. She is also licensed in the District of Columbia. And she is board-certified in emergency medicine.

21. Other than this proceeding, the Respondent has not been subject to any disciplinary action by the medical boards of Maryland or D.C.

22. In January 2015, the Respondent began working at the Health Center as the CMO. When she arrived, the executive leadership at the Health Center was in the process of implementing several operational changes, including changes to scheduling and reimbursement. One of the operational changes was a transition to open access scheduling where a patient could be scheduled for any point throughout the day, rather than allocating specific time slots for specific types of appointments such as well-child appointments or sick appointments.

23. While employed at the Health Center, the Respondent spent eighty percent of her time on administrative work and twenty percent on clinical work, providing care to the Health Center's refugee program at the Franklin Park location. Because of staff turnover, she also served, at various times, as acting HCMD at the Franklin Park, Takoma Park, and Gaithersburg locations.

24. The Respondent's personnel file contained no documentation of any complaints made about the Respondent by any patients of the Health Center.

25. Prior to August 2017, the Respondent's personnel file contained no documentation of any complaint that was made to the Health Center about the Respondent's conduct by the Health Center employees, with the exception of an email from Dr. B1 on June 27, 2017.

26. The Respondent's personnel file contained no complaints from Dr. W, Dr. F., Dr. C, Dr. B2, or Ms. G.

27. Prior to September 2017, the Respondent's personnel file contained no documentation evidencing any disciplinary action taken against her as the result of complaints about her conduct or the performance of her duties and responsibilities as CMO.

28. On October 16, 2017, the Health Center sent the Board a Termination of Employment (Delegation Agreement) between the Respondent and a physician assistant. The Delegation Agreement stated that the Respondent had been involuntarily terminated by the Health Center.

Ms. CB

29. Ms. CB has a medical assistant certificate.

30. Ms. CB has worked at the Health Center since 2000. At the time of the evidentiary hearing, she was the Director of Operations. In that role, she oversaw operations at all the Health Center locations, including oversight of support staff such as medical assistants, patient representatives, referral specialists, and HCMs.

31. From approximately 2014 until 2017, Ms. CB was the HCM for the Franklin Park location. For approximately a year and a half, the Franklin Park location did not have a HCMD, and, as a result, she was required to be in close contact with the CMO to discuss any issues with providers.

32. On an unspecified date in 2017, the Respondent told Ms. CB that Dr. F was a "privileged white woman" when Ms. CB and the Respondent were discussing a complaint that Dr. F made regarding the schedule at the Franklin Park location.

33. On an unspecified date, Ms. CB observed Dr. F crying in her office after the Respondent had left her office. Dr. F stated, "I want [human resources] present every time I'm going to talk to [the Respondent]."

34. On an unspecified date, in a conversation with Dr. B2, the Respondent referred to Ms. CB and other Hispanic staff at the Franklin Park location as a "Salvadoran" group of some type.

35. On an unspecified date, Ms. CB complained about the Respondent's behavior to her direct supervisor, Mr. D, who told Ms. CB not to worry about it and to just ignore the Respondent.

36. On or about January 2017, Ms. CB was promoted to Director of Operations, with responsibility for oversight of operations at all Health Center locations. Her supervisor was Dr. B3, the COO.

37. On or about August 14, 2017, Ms. CB was running a managers' meeting that started in the morning. The meeting did not conclude before lunch. She was eating lunch in the lunchroom with Ms. G and Ms. A at the Franklin Park location when the Respondent came in and asked Ms. CB, "Did you receive my text?" The text in question was asking for a progress update regarding a program to provide backpacks to children. Ms. CB said, "I'm eating lunch right now—I'll reply to it when I'm done." The Respondent then approached Ms. CB and said, "I'll need to know because I was meeting with these people." Ms. CB responded, "I'll reply to you when I'm finished eating." The Respondent was walking out of the lunchroom with her back turned to Ms. CB, and Ms. CB said, "Could you reply to that email that I sent to you." The Respondent stated, "I have a million emails, and I'll reply when I get to it." Ms. CB stated, "It's important, could you reply?" The Respondent responded with a raised voice: "I'll reply when I reply." The Respondent then left the lunchroom, slamming the door on the way out.

38. On August 15, 2017, Ms. CB went to the Health Center headquarters in Silver Spring for an executive meeting regarding a program to purchase discounted medication from an outside company. Ms. CB was responsible for purchasing medications. The meeting included the Respondent and Ms. KK, CEO of the Health Center; Dr. MC, Director of Quality; Mr. K, CFO; and Dr. B3, COO. The outside company was called into the meeting. When Ms. CB entered the

conference room, prior to the meeting commencing, the Respondent, Dr. C, and Mr. K were in the room. The table in the conference room had about ten chairs. Ms. CB started to walk towards the seat at the head of the table. The Respondent said to Ms. CB, "You can't sit there." After Ms. CB sat at a different seat, the Respondent stated, "You know why I'm telling you this, right?" Ms. CB was upset and mumbled with her head down, "I can't believe I'm getting etiquette lessons on where to sit so early in the morning." The Respondent asked Ms. CB to follow her out of the room to an adjacent room and explained to Ms. CB that she was trying to teach her a lesson regarding where to sit at meetings. When speaking with Ms. CB in the adjacent room, the Respondent's face was approximately ten inches away from Ms. CB's face. When Ms. CB tried to walk away, the Respondent tried to get in front of her to prevent her from leaving the room. When Ms. KK arrived at the meeting, she did not sit in the seat that Ms. CB was walking towards when she entered the room.

39. On August 17, 2017, in response to the incident at the meeting, Ms. CB sent an email to the CEO, Ms. KK, asking to meet to address the Respondent's treatment of her.

Dr. B2

40. Dr. B2 is licensed as a physician in Maryland and Alabama. He is board-certified in pediatrics.

41. The Respondent interviewed and hired Dr. B2 to work at the Health Center, and he began working at the Health Center in September 2015. Dr. B2 was the HCMD for the Franklin Park location until approximately February 2018.

42. On an unspecified date, Dr. B2 and the Respondent were meeting in Dr. B2's office, which was adjacent to Ms. CB's. The Respondent said that they needed to bring Ms. CB into the discussion. Dr. B2 had only two chairs in his office and said that he would get a chair for Ms. CB.

The Respondent told him not to get a chair. Dr. B2 asked where Ms. CB was going to sit. The Respondent responded, "I am going to show you a power move." Dr. B2 replied that he was not into "power games." The Respondent said, "Well, I am." Ms. CB entered Dr. B2's office and stood during the discussion before sitting on a box. After the meeting concluded, Dr. B2 reported the conversation to Ms. CB.

43. On an unspecified date, while discussing Ms. CB, the Respondent directed Dr. B2 to only meet with staff, including Ms. CB, in his office in order to establish his role as the leader of the location.

Dr. F

44. Dr. F was employed at the Health Center from approximately November 2010 through September 30, 2016. She started as a pediatrician and then became the patient-centered medical home champion with responsibility for ensuring that the Health Center became certified as a patient-centered home through the National Committee for Quality Assurance. In 2014, she became HCMD for the Health Center's Takoma Park location. She is board-certified in pediatrics.

45. The Respondent called Dr. F "cowgirl" and told her to "holster her guns" on multiple occasions in reference to Dr. F's practice of making comments in meetings.

46. On an unspecified date in 2015, the HCM for the Takoma Park location left her position. Dr. F was not involved in the interview process for the new HCM. When she approached the Respondent about not being involved and requested to be involved in the future, the Respondent stated, "If we had wanted your opinion, we would have asked."

47. In January or February 2016, on a Friday, Dr. K witnessed a parent spank their child in the Health Center's Takoma Park office. Dr. K informed the parent that she was considering reporting the parent to Child Protective Services ("CPS"), and the parent threatened Dr. K. Over

the weekend, Dr. F drafted an email addressed to Dr. K recommending that she report the incident to CPS and that the patient be discharged from the Health Center's care. Over the weekend, the Respondent spoke with Dr. K and decided that the family would not be discharged from the Health Center. On Monday, when Dr. F sent the draft email to the Respondent for her review, the Respondent called to inform Dr. F that she had taken care of the situation. Dr. F first found out that the situation had been resolved by the Respondent's Monday call.

48. In June or July 2016, the Respondent attended the monthly staff meeting at the Takoma Park location. After the meeting, the Respondent said to Dr. F, "Be careful standing upright in front of people of color, people might take that the wrong way."

49. Dr. F cleaned out her office six weeks in advance of her departure date from the Health Center out of fear that she would be walked out of the building prior to her departure date. After submitting her letter of resignation, she requested that all interactions with the Respondent be supervised by someone from the human resources department.

Dr. W

50. Dr. W is board-certified in pediatrics.

51. Dr. W was employed as a pediatrician at the Health Center's Takoma Park location from June 2015 through the end of September 2017.

52. From summer 2016 until she left the Health Center, Dr. W was the lead physician on certain Health Center initiatives, including nutritional counseling for obese patients, comprehensive education for asthma patients, and placement of interns.

53. While at the Health Center, Dr. W was in the practice of writing letters of support of children in certain immigration proceedings. The letters stated that Dr. W was the child's pediatrician and that the child's health was best served by remaining in the U.S. with the child's

parents. The letters were to be used in immigration proceedings by lawyers representing the child and their parents. The practice was encouraged by the American Academy of Pediatrics ("AAP").

54. In March or April 2017, the Respondent was at the Takoma Park location when Dr. W passed her in the hallway and attempted to schedule a time to discuss the letters. The Respondent said that they should just talk about the issue there and then. Dr. W asked that they go into a room to discuss for privacy purposes, but the Respondent insisted on discussing the issue in the hallway of the clinic. Dr. W attempted to explain her position on why it was appropriate to write the letters, referencing the guidance from the AAP. The Respondent used a raised voice and told Dr. W that she was acting outside the scope of her practice by writing the letters.

54. In March or April of 2017, the Respondent came to Dr. W to discuss her use of too many patient rooms at one time. Dr. W responded by offering suggestions on how to move people more quickly through the clinic. The Respondent told Dr. W that she was acting like a prima donna by using another provider's room and that she needed an attitude change.

55. Dr. W saw the Respondent approximately three times each month. The Respondent raised her voice in approximately half of the conversations she had with Dr. W.

56. After Dr. W informed the Respondent that she signed a contract with a different employer, the Respondent and Dr. W met for an exit interview. At the exit interview, the Respondent told Dr. W, in essence, that she thought that one of the reasons Dr. W did not like having the Respondent as her supervisor was because it was challenging for Dr. W to be corrected by an African American woman, because the information that African American women give is often misinterpreted, especially in comparison to a white supervisor, and that is why Dr. W may have taken offense at some of things the Respondent said to her.

Dr. B1

57. Dr. B1 is licensed to practice medicine in Maryland and in the District of Columbia. She is board-certified in pediatrics.

58. Dr. B1 worked at the Health Center from November 2012 to June 2016 as the HCMD for the Gaithersburg location.

59. Dr. B1 met with the Respondent two times each month with the other HCMDs. She also met at least once or twice a month with all senior managers, including the Respondent, at the Health Center's headquarters in Silver Spring.

60. In May 2016, Dr. B1 attempted to obtain vaccine records from a different medical practice for a patient whose parents were separated. She called the other practice directly but the person she spoke to refused to give her the records. Dr. B1 called the Respondent to let her know what had happened and to seek her assistance to address their refusal to furnish the records, and the Respondent asked, "Do you think you could have handled that differently?" Dr. B1 said, "No." The Respondent then stated, "I don't think you handled that well at all. You should have let your medical assistant handle it. You made the whole clinic get backed up."

61. A few weeks after the vaccination incident, the Respondent called a meeting with all the HCMDs to discuss ways to improve scheduling at the Health Center. Each HCMD took a turn and gave suggestions for scheduling changes. When it was Dr. B1's turn to speak, she began by explaining that when she worked in New York her employer had effective ideas. Before Dr. B1 could explain, the Respondent stated in a harsh tone, "We all know you come from New York, just get to the point." Dr. B1 was going to explain the two different ways of open access scheduling that she had experienced while practicing in New York.

62. In a telephone conversation subsequent to the above two incidents, Dr. B1 informed the Respondent that she had been very disrespectful to Dr. B1 and had humiliated her. In response to the conversation with Dr. B1, the Respondent repeatedly asked to meet with Dr. B1. Eventually, they agreed that the Respondent would meet with Dr. B1 *after* the monthly staff meeting in late May or early June 2016.

63. On the date of the scheduled meeting, however, the Respondent showed up at the beginning of the meeting and sat in on the meeting. Dr. B1 was explaining the details of a new bonus program to the thirty-five staff members at the Gaithersburg site. The Respondent interjected, stood up and stated, "That's incorrect . . . let me correct you . . . let me tell you what's really going on." The Respondent then gave the details of the bonus program. Dr. B1 had not been notified that the program had changed. After the meeting, Dr. B1 and the Respondent went to Dr. B1's office, and Dr. B1 told the Respondent that she had humiliated her in front of her staff and that this affected her ability to be a leader at the Gaithersburg location. When Dr. B1 stood up to leave her office, the Respondent placed her hand on Dr. B1's wrist and told her she could not leave and that they had to work it out. Dr. B1 told the Respondent she had to go, and the Respondent pulled away from Dr. B1.

64. On or about June 27, 2016, Dr. B1 sent an email to Ms. KK, the Respondent, and Mr. AB, the Health Center's Director of Human Resources, and requested that, because of the hostile and unprofessional behavior of the Respondent, someone from the human resources department be present for each meeting and be copied on all email communications between the Respondent and Dr. B1. About thirty minutes later, Dr. B1 sent her resignation letter informing the Health Center that her last day of work would be July 22, 2016. Later that week, Mr. AB came to Dr. B1's office and told her she had to leave that day and that she could not return. Dr. B1 was

seeing patients that day and was not given any time to finish her forty to fifty outstanding charts. Mr. AB informed Dr. B1 that the Respondent and Ms. KK had sent him, and that he was just the messenger. Dr. B1 cried as her staff packed her things.

65. About three weeks after Mr. AB walked her out of the building, he called Dr. B1 to let her know that she could come to the office to complete her outstanding charts.

EXCEPTIONS

The ALJ concluded that the Respondent engaged in disruptive behavior while working in medical offices, constituting unprofessional conduct in the practice of medicine, in violation of § 14-404(a)(3)(ii) of the Health Occupations Article. The Respondent's exceptions are divided into four areas. The Respondent argues: (1) the conduct, if proven, does not constitute unprofessional conduct in the practice of medicine (Exceptions at 13-14); (2) the Respondent's due process rights were violated (Exceptions at 2-5); (3) that, as a factual matter, the State failed to prove that the Respondent's conduct was disruptive (Exceptions at 5-13); and (4) the sanction the ALJ proposed was disproportionate and punitive (Exceptions at 15).

I. Whether the Respondent's conduct constitutes unprofessional conduct in the practice of medicine

The ALJ determined that disruptive behavior constitutes unprofessional conduct in the practice of medicine. The Respondent first argues that unprofessional conduct has not been found for "statements alone" when the statements were not false or fraudulent or do not improperly disclose confidential patient information. The Respondent's contention is unpersuasive. Although not at issue in this particular case, but contradicting the Respondent's point, is that comments constituting sexual harassment and inappropriate statements of a sexual nature have been found to be unprofessional. Verbal threats of violence are certainly unprofessional. Here, though, the

Respondent's unprofessional conduct was not limited to statements. On two occasions, the Respondent inappropriately confronted co-workers physically.

In analyzing terms such as "unprofessional conduct," the Court of Appeals found that the meaning of such terms "is determined by the 'common judgment' of the profession as found by the professional licensing board." *Finucan v. Maryland Board of Physician Quality Assurance,* 380 Md. 577, 593 (2004). Similarly, the Court of Appeals stated, "[c]ertainly the Board has a high degree of expertise in determining what constitutes unprofessional conduct 'in the practice of medicine.'" *Board of Physician Quality Assurance v. Banks,* 354 Md. 59, 76 (1999). Likewise, in a contested case, "[t]he agency . . . may use its experience, technical competence, and specialized knowledge in the evaluation of evidence." State Gov't § 10-213(i). The Court of Appeals found that unprofessional conduct "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." *Finucan,* 380 Md. 577, 593 (2004) (internal quotation marks omitted). The Panel, based upon its experience and specialized knowledge in practicing medicine, concludes that it is commonly understood in the profession that the Respondent's disruptive conduct was unprofessional. The Respondent's disruptive behavior, which included a pattern of demeaning, intimidating, and bullying coworkers, threatened the quality of patient care at the Health Center, constituted unprofessional conduct. Clearly, the Respondent's disruptive behavior at issue is unbecoming a member in good standing of a profession.[2]

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[2] The ALJ found that the Respondent's "conduct was unprofessional because it breached the AMA's Code of Medical Ethics." The Panel is not basing its finding of unprofessional conduct on a breach of a rule or ethical code of the profession because the basis for the ALJ's analysis of the Code of Medical Ethics in this case is unclear. The ALJ discusses, and seems to rely on, Opinion 9.045 of the AMA Code of Medical Ethics, but that opinion was not admitted into evidence.

The Respondent further contends that the Respondent's conduct was not "in the practice of medicine," because, according to the Respondent, the term applies to diagnosing and treating patients as well as to misconduct that relates to the effective delivery of patient care. In *Board of Physician Quality Assurance v. Banks,* 354 Md. 59 (1999), which addressed sexual harassment of hospital employees (mostly clerical staff) by a physician, the Court of Appeals applied a broad interpretation of "in the practice of medicine." The Court of Appeals based its determination that Dr. Banks' unprofessional conduct occurred in the practice of medicine on the findings "that Dr. Banks was on duty at the hospital, and was present in the working areas of the hospital" and that his conduct posed a threat to patient care. *Id.* at 74-75. The *Banks* Court further explained that courts have *not* applied "an extremely technical and narrow definition of the practice of medicine" and noted that clerical tasks such as billing third party payors has been found to be in the practicc of medicine for disciplinary purposes. *Id.* The Respondent's conduct at issue squarely falls within the "in the practice of medicine" of Health Occ. § 14-404(a)(3)(ii). *Id.* 74-77.

II. Due Process

The Respondent's due process argument concerns two areas: (1) interview transcripts admitted into evidence and relied upon by the ALJ, and (2) the ALJ's characterization of the Respondent's testimony as "self-serving," while not finding as "self-serving" the testimony of the State's witnesses who testified they were victims of the Respondent's behavior.

a. Interview Transcripts

The Respondent contends that there was a due process violation based upon "the fact that the Respondent was not invited or permitted to be present at any of the interviews" conducted by the Board investigators. During the OAH hearing, the Respondent objected to the admission of the interview transcripts, partly based upon the Respondent not being allowed to attend the

interviews of the other witnesses. The ALJ denied the objection. In the proposed decision, the ALJ quoted *Rosov v. Maryland Bd. of Dental Exam'rs,* 163 Md. App. 98, 115 (2005): there is "'no requirement, either in law or investigative technique, that compels an investigative agency, prior to charging, to include the investigation target or counsel in the interview process.'" The Respondent has not provided any legal authority indicating otherwise. The Panel finds there was no due process violation in not inviting or permitting the Respondent to be present during the investigative interviews of the witnesses.

The Respondent further contends that the ALJ gave too much weight to the interview transcripts, as opposed to the live testimony presented during the evidentiary hearing at OAH. Again, the Respondent provides no legal authority on point to support her claim of a due process violation on this basis. This argument may relate to whether the ALJ gave too little or too much weight to certain evidence, but it does not demonstrate a due process violation. The Respondent's exception is denied.

b. Self-Serving Testimony Findings

The ALJ based the credibility finding of the Respondent on several factors, one of which was the ALJ's determination that the Respondent's testimony was "self-serving" "as compared to the State's witnesses." (Proposed Decision at 22, 27.) The Respondent relies upon *Travers v. Baltimore Police Department,* 115 Md. App. 395, 417 (1997), to argue the ALJ erred by giving less weight to the Respondent's testimony because it was "self-serving," but not giving less weight to the State's witnesses as "self-serving," even though certain State witnesses testified that they were victims of the Respondent's conduct. *Travers* states, "Ordinarily, a complaining witness who is also a 'victim' cannot be viewed as neutral and detached." *Id.* at 417. The Panel finds merit to this exception. Here, several of the State's witnesses testified that they were victims of the

Respondent's conduct. These State witnesses do, as *Travers* suggested, have "an interest in the subject matter underlying the controversy." Their testimony is not neutral and disinterested.

The Panel, therefore, finds that the ALJ erred by considering the Respondent's testimony to be less credible than these State witnesses on the basis that the Respondent's testimony was "self-serving" as compared to the testimony of these State witnesses. The Panel has, therefore, not viewed the Respondent's testimony as less credible than the State witnesses who testified that they were a victim of the Respondent on the basis that their testimony was less self-serving than the Respondent's. The Panel, therefore, has given minimal weight to any self-serving aspect of the testimony, in considering the credibility of both the Respondent and these State witnesses.

III. Factual disputes

The Respondent's statements and actions often demeaned and embarrassed her work colleagues at the Health Center. These incidents demonstrate a pattern of behavior that was unprofessional. In determining the facts of these incidents, the Panel assessed the credibility of the witnesses. For the most part, the Panel found the State's witnesses to be more credible than the Respondent, and thus the Panel extensively relied on the testimony of the State's witnesses. The Respondent's version of each of the interactions at issue was generally not accepted. The Respondent almost uniformly testified that she was always calm, spoke conversationally, and was appropriate under the circumstances. For instance, in the lunchroom incident involving Ms. CB, the Respondent said she was conversational, matter of fact, and did not slam a door, while Ms. CB said the Respondent's voice was raised and "pretty much slammed the door." (T. 68.) More significantly, another witness to the incident, Ms. G, said that the Respondent was upset, yelling, pointing her finger, "stormed out and slammed the door." The discrepancy between the Respondent's version and that of both Ms. CB and Ms. G is so stark that it significantly

undermined the Respondent's credibility. Similar to what Ms. CB and Ms. G described, Dr. W indicated that it was routine for the Respondent to raise her voice, which occurred when there were disagreements. Another incident which also significantly diminished the Respondent's credibility involved the box that Ms. CB sat upon during a meeting with Dr. B2 and the Respondent. The Respondent told Dr. B2 that she was going to show him a "power move." There is no indication that Dr. B2 fabricated this conversation. Dr. B2 was not a victim or target of the Respondent's conduct. The Respondent's denial of the comment is not credible. The "power move" comment is also consistent with the behavior of the Respondent as described by other State witnesses. Reliable testimony by the State's witnesses overwhelmingly demonstrates the implausibility of the Respondent's versions of events. There were numerous similar incidents in which the Respondent inappropriately raised her voice, physically intimidated colleagues, and used petty power moves. A clear pattern of the Respondent's unprofessional behavior was established through the testimony of several witnesses concerning numerous incidents. Thus, in general, when there were disputes between the State's witnesses and the Respondent's versions of events, the Panel found the Respondent's testimony unreliable.

a. Ms. CB

1. Conference Room

An executive meeting with several Health Center officers and staff was scheduled for on or about August 15, 2017, in the conference room of the Health Center's headquarters. Before the meeting, when Ms. CB walked into the conference room, the Respondent was already there, along with two others. Ms. CB started to walk to a seat at the head of the table. Seeing this, the Respondent told Ms. CB that she could not sit there because that was where the CEO usually sat. Ms. CB heeded the warning and sat in another seat. The Respondent, nonetheless, continued on

the subject, asking Ms. CB, "You know why I'm telling you this, right?" Ms. CB responded, "I can't believe I'm getting etiquette lessons on where to sit so early in the morning." The Respondent then decided to ask Ms. CB to follow her into another room so she could continue the lesson on where to sit at meetings. In the other room, the Respondent stood so her face was approximately ten inches away from Ms. CB's face. When Ms. CB tried to walk away, the Respondent tried to get in front of her to prevent her from leaving the room. In the end, the CEO did not sit in the seat that the Respondent told Ms. CB not to sit in.

The Respondent took exception, first arguing that the charging document was fundamentally flawed because it states that Ms. CB felt bullied and humiliated by an encounter with the Respondent immediately prior to the executive meeting. According to the Respondent's exceptions, the charge was based upon Ms. CB's feelings and not on any conduct on the part of the Respondent. The charges, however, state that certain employees at the Health Center reported feeling emotionally abused, demoralized and humiliated based upon the "Respondent's hostile, disrespectful, rude, condescending, and unprofessional behavior." (Charges at 6, ¶ 16.) The charges concern the Respondent's conduct. The Respondent's exception is not accepted.

The Respondent next argues that the Respondent's conduct was not unprofessional. The Respondent contends that her tone was appropriate and she reasonably "did not want to see Ms. CB embarrassed so she offered a tip about their mutual boss." (Exceptions at 6.) Relying upon the testimony of Mr. K, CFO, the Respondent further maintains that it was Ms. CB who was disrespectful by responding in a "sarcastic" manner to the Respondent's admonishment concerning the CEO's usual seat. According to the Respondent, "[n]o reasonable objective person would construe the statement Respondent made as something inappropriate, much less unprofessional." (*Id.*)

The Respondent's exception does not convince the Panel that the Respondent's conduct was not unprofessional, because the exception does not address a crucial portion of the incident, which is the interaction between the Respondent and Ms. CB in the neighboring room. After their exchange in the conference room, the Respondent escalated the matter by asking Ms. CB to go into another room so she could extend her lesson on seating etiquette. In the other room, where Mr. K, CFO, was not present, the Respondent attempted to physically intimidate Ms. CB by speaking to her at an unnecessarily close distance and then trying to physically block Ms. CB from leaving the room. Notifying a colleague that she should not sit in a particular seat does not merit a confrontation involving physical intimidation. Moreover, there is further context to this incident, which includes an interaction between the Respondent and Ms. CB that occurred the day before in an office lunchroom.

2. *Lunchroom*

The day before the seating etiquette incident, Ms. CB was running a managers' meeting that did not conclude before lunch. While Ms. CB was eating lunch in the lunchroom with Ms. G and Ms. A, the Respondent walked in and asked Ms. CB about a text the Respondent had sent her. Ms. CB told the Respondent that she would respond after lunch. The Respondent then said that she needed a response quickly because the information was needed for a meeting the Respondent was having soon. Ms. CB reiterated that she would reply after she finished her lunch. Ms. CB then asked the Respondent to respond to an email Ms. CB had sent the Respondent. The Respondent replied, "I have a million emails, and I'll reply when I get to it." Ms. CB explained that it was important, and the Respondent raised her voice and said, "I'll reply when I reply." The Respondent then left the room, slamming the door on her way out.

The Respondent took exception to the ALJ's findings on this incident, asserting that on cross examination Ms. CB "conceded that it was after telling the Respondent she couldn't respond to her text until she finished eating her lunch, that she then yelled at Respondent from across the room, as the Respondent was leaving and had her back to Ms. [CB], to respond to an email Ms. [CB] sent to her." (Exceptions at 7.) The Respondent's exception, however, does not cite to any evidence other than the testimony of Ms. VM, who, according to the Respondent, "testified that she never witnessed any unprofessional behavior by the Respondent at any time." (*Id.*) But the Respondent concedes that Ms. VM "was not at the lunch during this meeting." (*Id.*) On the other hand, Ms. G was present during this incident and testified that Ms. CB always remains "calm," and that during this incident the Respondent "pointed her forefinger at [Ms. CB]," "stormed out" of the room, was "inappropriate, kind of disrespectful," "slammed the door," and was "yelling." (T. at 199-201.) Ms. G's eyewitness testimony corroborates Ms. CB's account. The exception is denied.

3. The Box

The Respondent and Dr. B2 were meeting in Dr. B2's office and the Respondent said that Ms. CB should take part in their discussion. There were two chairs in Dr. B2's office, so Dr. B2 said that he should get another chair. The Respondent told Dr. B2 that he did not need to get another chair, and thus Dr. B2 asked the Respondent where Ms. CB was going to sit. The Respondent replied, "I'm going to show you a power move." Dr. B2 responded that he was not into "power games." The Respondent said, "Well, I am." Dr. B2 got Ms. CB, and Ms. CB came into his office and sat on a box.

The Respondent's exception to the ALJ's findings regarding the box incident argues, essentially, that Ms. CB's description of the incident was untrustworthy. The Respondent's

exception states, "Ms. [CB] admitted to devising an account of a meeting where she sat upon a box." (Exceptions at 7.) The Respondent, however, does not cite to the record to show where Ms. CB "admitted to devising an account" of the incident. Without any citation and being unable to locate the purported admission, the Panel does not accept the Respondent's claim that Ms. CB admitted to devising an account of the incident.

The Respondent further states that Ms. CB's "alleged memory of having to sit on a box was belied by her own testimony that . . . Respondent was standing the entire time." The Panel does not accept that, if the Respondent stood during the meeting, that must have meant that Ms. CB did not sit on a box. Because the Respondent told Dr. B2 not to get a third chair, there were only two chairs in the room. It is logical that, when Ms. CB came into the room, Ms. CB inferred from the Respondent's positioning and body language that one of the chairs was for the Respondent. Dr. B2 testified that Ms. CB "realized that there was no chair for her." (T. 453.) Even if one of the chairs went unused, it is likely that it was made clear to Ms. CB that there was not a chair designated for her to sit.

The main support for finding that the Respondent told Dr. B2 that he should not get a chair for Ms. CB and that the Respondent told him that she was going to show him a "power move" comes from the testimony of Dr. B2. Ms. CB was, obviously, not present when the Respondent told Dr. B2 that she was going to show him a "power move." Dr. B2's testimony was consistent with his Board interview, and the incident clearly had a significant impact on him. The Respondent points out that Dr. B2 did not recall the substance of the issue that the three discussed. This, however, does not undermine Dr. B2's testimony, because the Respondent's "power move" was so out of the ordinary to Dr. B2 that it is likely to have overshadowed the substance of the

discussion with Ms. CB, which most likely was within the normal realm of business. The Panel accepts the testimony of Dr. B2. The exception is denied.

4. Salvadoran group

The ALJ found that, on occasion, the Respondent referred to certain employees with an Hispanic background in a derogatory and demeaning manner by calling them the "Salvadoran" gang, mafia, or posse. The Respondent took exception, arguing, in essence, that any such reference was not meant to be demeaning. While the Panel certainly does not believe this type of language promotes a positive environment in an office setting, the Panel does not believe it rises to the level of "unprofessional conduct."

5. Ms. CB's credibility

The Respondent argues that Ms. CB is not credible because an employee at the Health Center described Ms. CB as "difficult" and that the COO heard of complaints pertaining to Ms. CB's management style. The Respondent further relies upon evidence that the Respondent and Ms. CB "were texting and Respondent was picking up lunch for" Ms. CB. The Panel does not find these points compelling, especially because there is substantial corroboration that the Respondent acted against Ms. CB in an unprofessional manner. The Respondent's behavior against Ms. CB constitutes unprofessional conduct in the practice of medicine.

b. Dr. F

On a Friday, in January or February 2016, Dr. K witnessed a mother spank her child at the Health Center. Dr. K told the parent that she was considering reporting the incident to Child Protective Services ("CPS"). The parent responded by threatening Dr. K by telling Dr. K that she was going to return to the office with a firearm. Dr. F was not a witness to the incident, but she was the immediate supervisor of Dr. K, and Dr. F believed the incident should be reported to CPS.

Over the weekend, Dr. F drafted an email that she wanted to send to Dr. K, which was intended to convince Dr. K to report the incident to CPS and which also stated that she thought the family should be discharged from the Health Center because of the threat of violence. On Monday, Dr. F sent the email to the Respondent to review before Dr. F sent it to Dr. K. After receiving the email, the Respondent called Dr. F and told Dr. F that the situation had been taken care of. The Respondent and Dr. K discussed the matter over the weekend, and the Respondent decided that the family would stay with the Health Center and that the incident would not be reported to CPS. Dr. F was upset that the Respondent did not consult with her before making a decision that involved a physician Dr. F. supervised.

The Respondent argues that the Respondent handled the situation appropriately. The Respondent spoke with Dr. K and weighed the important factors involved in the decision.

The merits of the Respondent's decisions to not discharge the patient/family from the Health Center and to not report the incident to CPS are not before the Panel. Instead, the Panel has considered whether the Respondent's conduct toward Dr. F in making those decisions indicates unprofessionalism. While the Respondent's decision to not consult with Dr. F before making her decisions on this particular matter upset Dr. F, the Panel does not find that this reaches the unprofessional conduct level. It is possible the Respondent felt that, because Dr. K was a direct witness to the incident and was most involved, Dr. K was the most important person with whom to discuss that matter. The Panel, however, finds that other conduct by the Respondent toward Dr. F was unprofessional.

The Respondent referred to Dr. F as a "cowgirl" and, to discourage her from voicing her opinions at meetings, told Dr. F, on multiple occasions, to "holster her guns." Likewise, after a

meeting in June or July 2016, the Respondent told Dr. F, "be careful standing upright in front of people of color, people might take that the wrong way."

In 2015, the Respondent did not involve Dr. F in the hiring of the health care manager at the location where Dr. F worked. When Dr. F mentioned to the Respondent that she thought she should have been involved and should be part of these hiring decisions in the future, the Respondent said, "If we wanted your opinion, we would have asked." The Respondent contends that Dr. F did not realize that "the Respondent had no authority to hire a new health care manager." The health care managers fall under the COO's supervision. Again, the Panel does not find the Respondent's decision to not involve Dr. F in the hiring process to be unprofessional. Rather, it was the manner in which the Respondent dismissed Dr. F's concerns that denotes unprofessionalism. The Respondent had a clear pattern of demeaning and belittling Dr. F. The Respondent's behavior toward Dr. F constitutes unprofessional conduct in the practice of medicine.

c. Dr. B1

Dr. B1 is a pediatrician and was seeing a new patient, but Dr. B1, after three visits had not been able to obtain the child's vaccination record from the patient's previous provider. Dr. B1 called the other provider, but the other provider did not release the records. Dr. B1 was very concerned about not having the records and was most concerned about whether the child had been vaccinated for measles. Dr. B1 called the Respondent to discuss the situation and to inquire whether they should pursue an action against the provider for not releasing the records.

The Respondent asked Dr. B1 what she thought she should have done differently. Dr. B1 said that she did not think she could have done anything differently. The Respondent said she disagreed and that Dr. B1 was spending too much time trying to obtain the records and that a

medical assistant should be making that effort. In terms of pursing an action against those with the other provider, the Respondent declined that route and said she thought Dr. B1 was overreacting. Dr. B1 did not feel that the Respondent understood how important the records were. In any case, the conversation "did not end nicely." (T. 1305.)

A few weeks later, the Health Center's medical directors were having a meeting to discuss changes to their scheduling process. Dr. B1 had practiced in New York, and, at her position there, the facility at which she practiced used a scheduling system that was efficient and effective, so Dr. B1 wanted the Health Center to try that approach. When Dr. B1 spoke at the meeting, in order to explain how she learned of the system, she said that she had been in New York. The Respondent quickly cut her off and, in a very harsh and negative tone, said, "We all know you're from New York." The Respondent then told her to "just get to the point." The Respondent's conduct was disruptive, unhelpful, disrespectful, and unnecessary. Dr. B1 felt, reasonably, that the Respondent carried over into that meeting the negative feelings the Respondent had from their disagreement over obtaining the vaccination records.

Soon afterwards, in a regularly scheduled one-to-one phone conversation between Dr. B1 and the Respondent, the Respondent said she wanted to discuss "the elephant in the room," which, Dr. B1 testified, the Respondent indicated concerned Dr. B1's tone and behavior. Dr. B1 responded by telling the Respondent that the Respondent had been very disrespectful to Dr. B1. The Respondent said that they would just have to work through it and move beyond it.

Next, in June, the Respondent and Dr. B1 scheduled to meet one-on-one, in-person, at Dr. B1's location at 10:00 am. It was scheduled at 10:00 am, because Dr. B1 had a monthly staff meeting that day, involving approximately 35 employees, starting at 8:00 am. The Respondent, however, appeared early, at 8:00 am and attended Dr. B1's monthly staff meeting. The Respondent

had not attended one of these meetings before and her appearance was unexpected. At the staff meeting, a staff member asked about the Health Center's new bonus payment system. Dr. B1 attempted to answer the question. The bonus system had changed multiple times, but Dr. B1 had recently received an email describing its most recent iteration. While Dr. B1 was answering the question, the Respondent stood up, interrupted Dr. B1, and said, "Dr. [B1], that's wrong." The Respondent then gave a lecture on the bonus system. The system the Respondent described was not the same as was described in the most recent information given to Dr. B1. Dr. B1 was understandably upset, and she felt humiliated at being treated so disrespectfully in front of approximately 35 employees. The Panel is mindful that it is vital that employees obtain accurate information, but the circumstances leading up to the meeting, the pattern of the Respondent's behavior, the unexpected appearance of the Respondent at the meeting, and the aggressive manner in which the Respondent acted at the meeting lead the Panel to find that the Respondent intended to embarrass Dr. B1.

Immediately after this meeting, Dr. B1 and the Respondent met for their one-on-one conversation. Dr. B1 explained that she was thinking of leaving the Health Center because of the Respondent's behavior towards her. Dr. B1 was very upset and felt that she could not stay in the same room, at that time, with the Respondent. Dr. B1 stood up and told the Respondent that she had to go and see patients. The Respondent then grabbed Dr. B1's wrist, and the Respondent said that Dr. B1 could not leave because they had it work it out. Dr. B1 told the Respondent to get her hand off of her and that she was leaving the room. Dr. B1 then left the room.

Because of the Respondent's behavior towards her, Dr. B1 gave a resignation letter to the Health Center and requested that someone from the Health Center's human resources department be present so that she would not have to meet with the Respondent alone in person.

About three days later, Dr. B1 was escorted out of the facility.

The Respondent's exception focusses on the specific conversation between Dr. B1 and the Respondent concerning the vaccination records. The Respondent argues that they simply had a disagreement about how to resolve a records issue, that Dr. B1 was upset that the Respondent did not feel as strongly as Dr. B1 did about obtaining the records, and that the Respondent disagreed with Dr. B1's suggested course of action. The Respondent further argues that the Respondent's question—asking Dr. B1 how she could have handled the situation better—was appropriate and that Dr. B1's being upset at the question was unreasonable.

The Respondent's exceptions do not address the Respondent's conduct with respect to Dr. B1 after the vaccination records conversation, which was what ultimately led to Dr. B1 submitting her resignation letter. The Respondent's conduct with respect to Dr. B1 after the vaccination records conversation was set forth in detail in the ALJ's proposed decision in findings of fact 54-57. After the vaccination records conversation, the Respondent rudely interrupted and demeaned Dr. B1 at a meeting with the medical directors when Dr. B1 was trying to explain a scheduling process that Dr. B1 thought would improve their organization. Then, at the monthly staff meeting, the Respondent humiliated Dr. B1 through the disrespectful manner in which the Respondent corrected Dr. B1 in the discussion about the new bonus payment. After that meeting, when Dr. B1 and the Respondent were together one-on-one, Dr. B1 explained that she had to leave room. The Respondent grabbed her wrist and told her she could not leave.

If there were no unprofessional incidents following their discussion on the vaccination records, the vaccination records discussion would not merit inclusion in a finding of unprofessional conduct. But that discussion is part of the finding of unprofessional conduct because the Respondent's unprofessional conduct, with respect to her pattern of behavior toward Dr. B1,

emanated from that vaccination records discussion. The Respondent carried over her negative reaction from that discussion to later meetings in which the Respondent sought to demean and embarrass Dr. B1.

The Respondent's exceptions also dispute that the Respondent was responsible for humiliating Dr. B1 when Dr. B1 was escorted out of the facility by Mr. AB. Mr. AB told Dr. B1 that he was told to escort her out of the facility by the Respondent and the CEO. The Panel does not base its finding of unprofessional conduct on this incident (the escorting of Dr. B1 out of the clinic). There is insufficient information in the record about the decision to escort Dr. B1 out of the office to make a finding against the Respondent based on this specific incident.

To be clear, though, the Panel finds that the Respondent's conduct with respect to her treatment of Dr. B1, as explained above, constitutes unprofessional conduct in the practice of medicine.

d. Dr. W

Dr. W was a pediatrician who worked at the Health Center. Dr. W wrote letters in immigration court cases on behalf of her patients, based on guidance from the AAP. The thrust of the letters was that the patients would benefit medically by staying in the United States by continuing with the medical treatment they were receiving here. The Health Center, however, issued a mandate that the Health Center would not write letters to the courts on these immigration cases.

In March or April 2017, on an unrelated matter, the Respondent was at the Health Center location where Dr. W worked. When the Respondent was leaving that facility, Dr. W asked the Respondent whether they could set up a time when they could speak about reversing the Health Center's mandate concerning immigration letters. The Respondent said they could talk right then.

They were in a hallway, so Dr. W asked that they find another place to talk that was private. The Respondent declined, so they discussed the matter in the hallway. Dr. W testified that the Respondent raised her voice and was "very harsh and demanding about her perspective." Dr. W further described the tenor of the Respondent was accusatory, belittling, and condescending.

Later, the Respondent and Dr. W had a conversation concerning Dr. W's use of too many examination rooms. The concern was that Dr. W was using more rooms for her patients than the other physicians. The Respondent said that Dr. W was being a prima donna and needed an attitude change.

Dr. W said that the Respondent acted inappropriately in discussions in which they had a disagreement, and Dr. W estimated that the Respondent raised her voice in about half of the conversations they had.

Part of the reason Dr. W decided to leave the Health Center and work elsewhere was because of her negative interactions with the Respondent. After Dr. W notified the Health Center that she was leaving, the Respondent asked to speak with Dr. W for an exit interview. At the exit interview, Dr. W told the Respondent that the conversation in which she was called a prima donna was a big part of the reason why she was leaving. Dr. W testified that she "didn't want to be in a workplace that was calling [her] names."

Also, at the exit interview, the Respondent told Dr. W that Dr. W probably did not like working at the Health Center because the Respondent was African American and that taking orders and instructions from an African American woman was probably hard for Dr. W and that sometimes things that the Respondent said were misinterpreted. Dr. W responded that the Respondent calling her a prima donna had nothing to do with the color of the Respondent's skin.

The Respondent's exceptions state that Dr. W's testimony "established that Dr. [W] was challenging and speaking out against [the Health Center's] policy, which she knew and understood she had an obligation to follow." Again, the issue is not whether the substance of the Respondent's decision-making was appropriate. The Health Center had a clear policy. The significance of the conversation did not pertain to the merits of the Respondent's stance on the policy. The significance involves the manner in which the Respondent interacted with Dr. W. The Panel credits Dr. W's testimony that the Respondent raised her voice and was belittling and condescending.

The Respondent also took exception to the ALJ's finding that "the Respondent told [Dr. W] that she thought one of the reasons that Dr. [W] did not like working at the Health Center and found the Respondent challenging to work with because of the color of Respondent's skin." (ALJ's Proposed Decision at 16, ¶ 48.) The Respondent quotes Dr. W, in which Dr. W said the words were "something along the lines of when black women say things, it's interpreted differently than when white women say things or other people says things, and that was probably why I took offense to the things that she said." The Respondent contends that the ALJ omitted certain details "in a way seemingly designed to make Respondent's comment appear to be a racist remark.

Immediately before the testimony that the Respondent quotes, Dr. W also testified,

> And in that conversation she told me that the reason that I probably didn't like working at [the Health Center] was because she was black and that taking orders – you know, instruction from a black woman was probably hard for me and that sometimes things that she said were probably misinterpreted.

(T. 406-07.) The Respondent testified,

> I said to her something along the line of when – when we receive correction from a leader or someone who is our supervisor, it can be difficult to hear. And I shared with her that it had been my experience that when a leader is of a different ethnicity, especially

> as an African American woman, giving the same information, it can be taken differently than if a white male gives that same information.

(T. 1161.)

The Panel finds that the ALJ's finding left out some nuance. The Panel, therefore, finds that the Respondent told Dr. W, in essence, that she thought that one of the reasons Dr. W did not like working with the Respondent as her supervisor was because it was challenging for Dr. W to be corrected by an African American woman, because the information that African American women give is often misinterpreted, especially in comparison to a white supervisor, and that is why Dr. W may have taken offense at some of things the Respondent said to her.

With the addition of the words pertaining to African American women being misinterpreted, the Respondent's statement appears less like she was accusing Dr. W of being a racist and more like an attempt to explain that Dr. W took offense mistakenly, based upon some misinterpretation. The Panel, therefore, declines to base its finding of unprofessional conduct on this exit interview incident.

With that said, the Panel does not accept the Respondent's contention that the ALJ erred by finding that the Respondent called Dr. W a prima donna. The Respondent testified that she was relaying to Dr. W that some of the staff said she was acting like a prima donna. The Panel finds that the Respondent did call Dr. W a prima donna. Dr. W's version is more credible than the Respondent's. The Respondent has a pattern of using derogatory terms for her coworkers, and, as explained above, the Panel does not find the Respondent's testimony reliable. While this phrase is not so egregious by itself, it was made in the same conversation in which the Respondent said that Dr. W needed an attitude change. In this context, it was inappropriate. The Respondent's treatment of Dr. W was condescending and belittling and, combined with the Respondent's

harshness and her often-times raised voice, constitutes unprofessional conduct in the practice of medicine.

CONCLUSIONS OF LAW

Based upon the findings of fact and as explained in this decision, Panel B concludes that the Respondent is guilty of unprofessional conduct in the practice of medicine, in violation of § 14-404(a)(3)(ii) of the Heath Occupations Article.

SANCTION

As a sanction, the ALJ recommended that the Panel reprimand the Respondent, place the Respondent on probation for one year, order that the Respondent enroll in MPRP, and that the Respondent complete an intensive course regarding the management of health care professionals.

The Respondent took exception to the ALJ's proposed sanction. The Respondent argues that the proposed sanction is punitive and that there "was no evidence or finding regarding real or potential threat to any identifiable patient or the public."

The *Banks* opinion applies to the Respondent's case. The Court of Appeals in *Banks* upheld the Board's

> holding that Dr. Banks' conduct posed a threat to patients . . . because his conduct was a threat to the teamwork approach of health care which requires participation from a variety of hospital personnel in order to deliver effectively patient care. In fact, the evidence shows Dr. Banks's conduct affected the working environment so deleteriously that it caused hospital employees to avoid him.

Banks, 354 Md. at 75.

The ALJ thoroughly described how the Respondent's conduct negatively affected the delivery of quality medical care:

> First, the Respondent's behavior caused three physicians to resign from the Health Center, negatively impacting the continuity of care

> for their patients. Second, the Respondent's behavior caused both physicians and non-physicians to limit their interactions and communications with the Respondent, thereby impeding the free flow of information regarding the delivery of care. Third, the Respondent's behavior took an emotional toll on individuals, negatively impacting their ability to go about their day-to-day duties of providing efficient patient care.

(ALJ's Proposed Decision at 44-45.) The Panel adopts these findings by the ALJ.

The Respondent's conduct was distracting, demoralizing, and threatened patient care at the Health Center. Further, the Respondent's conduct was systemic. There was a clear pattern to the Respondent's behavior.

The ALJ's proposed sanction is tailored specifically to address the Respondent's conduct. Except for some slight modifications (for example, changing the course from management of health care professionals to one on professionalism), the Panel accepts the ALJ's proposed sanction.

ORDER

It is, by an affirmative vote of a majority of the quorum of Board Disciplinary Panel B, hereby

ORDERED that Respondent Marcia Bennette LoBrano is **REPRIMANDED**; and it is further

ORDERED that the Respondent is placed in **PROBATION** for a minimum period of **ONE YEAR.**[3] During probation, the Respondent shall comply with the following terms and conditions of probation:

1. The Respondent shall enroll in the Maryland Professional Rehabilitation Program

[3] If the Respondent's license expires while the Respondent is on probation, the probationary period, and any probationary conditions, will be tolled.

as follows:

(a) Within **5 business days,** the Respondent shall contact MPRP to schedule an initial consultation for enrollment;

(b) Within **15 business days,** the Respondent shall enter into a Participant Rehabilitation Agreement and Participant Rehabilitation Plan with MPRP;

(c) the Respondent 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) the Respondent 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 to MPRP. The Respondent shall not withdraw her release/consent;

(e) the Respondent shall also sign any written release/consent forms to authorize MPRP to exchange with (i.e., disclose to and receive from) outside entities verbal and written information concerning the Respondent and to ensure that MPRP is authorized to receive the health care records of the Respondent. The Respondent shall not withdraw her release/consent; and

(f) the Respondent'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; and

2. Within **six months,** the Respondent is required to take and successfully complete a course in professionalism. The following terms apply:

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

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

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

(d) the Respondent is responsible for the cost of the course; and it is further

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

ORDERED that, after the Respondent has complied with all terms and conditions of probation and the minimum period of probation imposed by the Order has passed, the Respondent 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. The Respondent may be required to appear before the disciplinary panel to discuss her petition for termination. The disciplinary panel will grant the petition to terminate the probation, through an order of the disciplinary panel, if the Respondent has complied with all probationary terms and conditions and there are no pending complaints with the Board related to the Respondent's conduct in the practice of medicine; and it is further

ORDERED that the Final Decision and Order goes into effect upon the signature of the Executive Director of the Board. The Executive Director signs the Final Decision and Order on behalf of Board Disciplinary Panel B; and it is further

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

ORDERED that, if the Respondent allegedly fails to comply with any term or condition imposed by this Order, the Respondent shall be given notice and an opportunity for a hearing. If a 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 a disciplinary panel determines there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before a disciplinary panel; and it is further

ORDERED that, after the appropriate hearing, if the disciplinary panel determines that the Respondent has failed to comply with any term or condition imposed by this Order, the disciplinary

panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke the Respondent's license to practice medicine in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on the Respondent; and it is further

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

Signature on File

10/26/2020
Date

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

NOTICE OF RIGHT TO APPEAL

Pursuant to § 14-408(a) of the Health Occupations Article, the Respondent has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review must be filed within 30 days from the date this Final Decision and Order was sent to the Respondent. The Final Decision and Order was sent on the date of the cover letter accompanying the Final Decision and Order. The petition for judicial review must be made as directed in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222, and Maryland Rules 7-201 *et seq.*

If the Respondent petitions for judicial review of this Final Decision and Order, the Board is a party and should be served with the court's process. In addition, the Respondent should send a copy of the petition for judicial review to the Board's counsel, David Wagner, Assistant Attorney General, Office of the Attorney General, 300 W. Preston Street, Suite 302, Baltimore, Maryland

21201. The administrative prosecutor is not involved in the circuit court process and does not need to be served or copied on pleadings filed in circuit court.