IN THE MATTER OF	*	**BEFORE THE**
CYNTHIA J. MOORMAN, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D54731	*	**Case Number: 2220-0106B**

* *

CONSENT ORDER

On December 4, 2020, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") charged Cynthia J. Moorman, M.D. (the "Respondent"), License Number D54731, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2014 Repl. Vol. & 2019 Supp.). Panel B charged the Respondent under the following provisions of the Act:

> **Health Occ. § 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> (a) *In general.* -- Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (3) Is guilty of: . . .
> (ii) Unprofessional conduct in the practice of medicine;
>
> (18) Practices medicine with an unauthorized person or aids an unauthorized person in the practice of medicine[[1]]; [and]

The pertinent provisions of the Code of Maryland Regulations are:

[1] Pursuant to Health Occ. § 14-101(o)(1), "'practice medicine' means to engage, with or without compensation, in medical: (i) Diagnosis; (ii) Healing; (iii) Treatment; or (iv) Surgery."

COMAR 10.32.12 Delegation of Acts by a Licensed Physician to an Assistant Not Otherwise Authorized under the Health Occupations Article or the Education Article

. . .

.04 Scope of Delegation

. . .

B. A physician may delegate technical acts consistent with national standards in the medical community and the approved policies and procedures of the sites for the delivery of health services in the following categories:

. . .

(2) Nonsurgical technical acts while the assistant is under the physician's direct supervision or on-site supervision if the assistant performs the act in accordance with procedures of the site.

. . .

D. At sites not included in Health-General Article, §§ 19-114 and 19-3B-01(b) . . . when providing the following specified levels of supervision, a physician may delegate to an assistant technical acts which include but are not limited to:

. . .

(2) With on-site supervision:

(a) Preparing and administering injections limited to intradermal, subcutaneous, and intramuscular (deltoid, gluteal, vastus lateralis) to include small amounts of local anesthetics;

(b) Establishing a peripheral intravenous line; and

. . .

(3) With direct supervision, injecting intravenous drugs or contrast materials.

. . .

F. A physician may not delegate to an assistant acts which include but are not limited to:

(1) Conducting physical examinations;

. . .

(3) Initiating independently any form of treatment, exclusive of cardiopulmonary resuscitation; [and]

(4) Giving medical advice without the consult of a physician[.]

.05 Prohibited Conduct.

. . .

B. A delegating physician, through either act or omission, facilitation, or otherwise enabling or forcing an assistant to practice beyond the scope of this chapter, may be subject to discipline for grounds within Health Occupations Article, § 14-404(a), Annotated Code of Maryland, including, but not limited to, practicing medicine with an unauthorized person or aiding an unauthorized person in the practice of medicine.

C. A delegating physician may not require an assistant to perform a delegated act.

Disruptive physician behavior is a form of unprofessional conduct in the practice of medicine. The Joint Commission and the American Medical Association ("AMA") have each addressed the problem of disruptive behavior:

The Joint Commission, SENTINEL EVENT ALERT, Issue 40, *Behaviors that undermine a culture of safety* (2008):

> Intimidating and disruptive behaviors can foster medical errors . . . contribute to poor patient satisfaction and to preventable adverse outcomes . . . increase the cost of care . . . and cause qualified clinicians, administrators and managers to seek new positions in more professional environments . . . Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.
>
> Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions . . . Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients . . . All intimidating and disruptive behaviors are unprofessional and should not be tolerated. . . .

AMA CODE OF MEDICAL ETHICS, Ch. 9 – Opinions on Professional Self-Regulation, Opinion 9.4.4, *Physicians with Disruptive Behavior* (2016):

> The importance of respect among all health professionals as a means of ensuring good patient care is foundational to ethics. Physicians have a responsibility to address situations in which individual physicians behave disruptively, that is, speak or act in ways that may negatively affect patient care, including conduct that interferes with the individual's ability to work with other members of the health care team, or for others to work with the physician. . . .

Treating oneself or family members is also a form of unprofessional conduct in the practice of medicine. The AMA has addressed the problems of treating oneself or family members:

AMA CODE OF MEDICAL ETHICS, Ch. 1 – Opinions on Patient-Physician Relationships, Opinion 1.2.1, *Treating Self or Family* (2016):

> Treating oneself or a member of one's own family poses several challenges for physicians, including concerns about professional objectivity, patient autonomy, and informed consent.
>
> When the patient is an immediate family member, the physician's personal feelings may unduly influence his or her professional medical judgment. Or the physician may fail to probe sensitive areas when taking the medical history or to perform intimate parts of the physical examination. Physicians may feel obligated to provide care for family members despite feeling uncomfortable doing so. They may also be inclined to treat problems that are beyond their expertise or training.
>
> Similarly, patients may feel uncomfortable receiving care from a family member. A patient may be reluctant to disclose sensitive information or undergo an intimate examination when the physician is an immediate family member. This discomfort may particularly be the case when the patient is a minor child, who may not feel free to refuse care from a parent.
>
> In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:
>
> (a) In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should

not hesitate to treat themselves or family members until another physician becomes available.

(b) For short-term, minor problems.

When treating self or family members, physician have a further responsibility to:

(c) Document treatment or care provided and convey relevant information to the patient's primary care physician.

(d) Recognize that if tensions develop in the professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

(e) Avoid providing sensitive or intimate care especially for a minor patient who is uncomfortable being treated by a family member.

(f) Recognize that family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

On February 24, 2021, Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of the DCCR, the Respondent agreed to enter this Consent Order, consisting of the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

Panel B finds:

I. BACKGROUND & LICENSING INFORMATION

1. At all relevant times, the Respondent was and is licensed to practice medicine in the State of Maryland. The Board first issued the Respondent a license to practice medicine in Maryland on May 18, 1999, under License Number D54731. Her license is active through September 30, 2021, subject to renewal.

2. The Respondent is board-certified in urology and practices as a urologist in Frederick, Maryland. She is a solo practitioner. She currently has privileges at a hospital ("Hospital A")[2] as well as an outpatient surgery center. The Respondent is also a partial owner of the outpatient surgery center.

II. COMPLAINTS

3. On or about September 27, 2019, the Board received an anonymous complaint alleging that the Respondent directed medical assistants[3] in her office to perform catheter changes and voiding trials while the Respondent was out of the office, to prescribe or refill medications without consulting the Respondent, to perform bacillus Calmette-Guérin[4] ("BCG") treatments without appropriate personal protective equipment ("PPE"), to perform patient assessments, and to complete documentation for the entire office visit including a diagnosis before the Respondent saw the patient. The complaint also alleged that the Respondent did not have sharps disposal containers in each examination room, often requiring staff to exit a room with an exposed sharp. The complaint further alleged that "verbal harassment and abuse exists" in the Respondent's practice because of her conduct including throwing items and repeated threats of termination.

4. On or about October 15, 2019, the Board received a second anonymous complaint alleging that the Respondent "upcodes" visits when billing, has "over 700 open

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[2] To maintain confidentiality, the names of all witnesses, facilities, employees, and patients will not be used in this Consent Order.

[3] Unless otherwise noted, the term "medical assistant" in these charges refers to an individual who is not certified, registered, or licensed by the Board or any other State health occupation board.

[4] BCG treatment is a form of immunotherapy that consists of instilling bacteria of *mycobacterium bovis* (bovine tuberculosis) in a reduced form into the bladder through a catheter. It is used to treat early stages of bladder cancer.

encounters," and has directed prior staff to sign off her encounters to close them. Attached to the complaint were printouts of inter-office emails in which the Respondent directed medical assistants to enter diagnosis codes in patient charts and requested that staff issue standard refill prescriptions for conditions such as overactive bladder.

III. BOARD INVESTIGATION

5. The Board initiated an investigation into the anonymous complaints.

A. Conduct at Hospital A

6. On or about November 12, 2019, in response to a Board subpoena, the Board received the Respondent's quality assurance/risk management file from Hospital A.

7. The Respondent's file included several documents titled "Report of Code of Conduct Issue" dated between October 2018 and September 2019. These reports addressed the following incidents:

a. October 2018 – A nursing supervisor reported that the Respondent was rude and disrespectful to both a nurse and the nursing supervisor when the nurse called the Respondent at 11:30 p.m. with concerns about a Foley catheter. The Respondent responded to the report by claiming that the nursing staff "DID NOT ONCE AGAIN KNOW THEY HAVE A CATH TEAM TO EVAL THESE SITUATIONS," [use of capitals in original] and "I guess I am suppose [*sic*] to sing a happy tune and then just be glad I could be of service to them in the middle of the night." The Surgical Department Review Oversight Committee (the "Committee") recommended education for the Respondent and emphasized that the on-call urologist must be notified when there is a catheter problem. The Committee also noted that it was unaware of a "catheter team" at the hospital to manage catheter related issues.

b. December 2018 – A staff member reported that the Respondent used profanity in and around the operating room following a timing dispute. The Committee admonished the Respondent to "refrain from using vulgar language in front of staff and patients."

c. March 2019 – A staff member reported that the Respondent entered the operating room while the patient was awake, yelled at the operating room team about room turnover time, and used profanity in front of the patient. The Committee concluded that "care was determined to be inappropriate; code of conduct was unmet; and citizenship was unmet." The Committee recommended education for the Respondent.

d. September 2019 – A staff member reported that the Respondent refused to consult on a patient who presented to the emergency room with kidney stones even though the Respondent previously treated the patient. The Respondent responded to the report by stating that the patient had an outstanding balance at her office and stormed out when told about it. The Committee concluded that there was "questionable care since a letter of discharge from services was not provided in a timely fashion, code of conduct is unmet[.]" The Committee recommended education for the Respondent.

8. The Respondent's file also included an October 18, 2019 email from a senior administrator at Hospital A to the Respondent about "concerns with [the Respondent's] escalating disruptive behavior including frequent use of profanity." The administrator explained that the Respondent's behavior may be interpreted as "hostile" and is disruptive to the clinical environment. The administrator noted that the Respondent had expressed frustration that the nursing staff was incompetent with no accountability for their actions.

B. Unannounced Site Visit

9. On or about March 3, 2020, Board staff conducted an unannounced site visit at the Respondent's practice. During the site visit, Board staff notified the Respondent of the complaints about her and served her with subpoenas for certain documents.

10. Also during the site visit, Board staff asked the Respondent where she stored the PPE for BCG treatments. The Respondent told Board staff that she uses only gloves and a mask when performing BCG treatments.

11. Board staff also observed an examination room at the Respondent's practice. They noted a portable sharps disposal container inside a wall cabinet. The office manager told Board staff that all examination rooms in the office had a similar sharps container.

C. Interview of Office Manager A

12. On or about April 10, 2020, Board staff interviewed a former office manager of the Respondent's practice ("Office Manager A") under oath. Office Manager A stated that she worked for the Respondent between August 2019 and January 2020.

13. Office Manager A explained that patients came to the Respondent's practice on days when the Respondent was not there and saw a medical assistant instead. Office Manager A also explained that the Respondent directed the medical assistants to prescribe antibiotics without needing to consult with her if a patient called and described symptoms of a urinary tract infection.

14. Office Manager A said that the Respondent permitted a medical assistant to perform BCG treatments independently. Staff had access to a mask and gloves for a BCG treatment, but, according to Office Manager A, should have had full gowns, eye shields, and shoe coverings. Office Manager A explained that the Respondent refused to purchase full PPE for the BCG treatments because it was too expensive.

15. Office Manager A also stated that the Respondent directed medical assistants to enter all of the encounter information, including a diagnosis and physical examination findings before the Respondent saw the patient. Office Manager A explained that the Respondent would enter the electronic note and change the note to her name, but she would not do certain parts of the physical examination. If a staff member questioned the process, the Respondent told that staff member to do their job or be replaced.

16. Office Manager A explained that the Respondent often failed to sign or close an encounter for several months. Despite this, the Respondent directed staff to submit claims for reimbursement based on the open encounters.

17. Office Manager A said that she observed the Respondent have "full blown tantrums, throwing, kicking stuff, yelling, and she would just walk out of the practice," sometimes while patients were still waiting to be seen. Office Manager A explained that on one occasion, the Respondent was upset with about the poor print quality of a document and yelled, "This is so f—ing stupid," then threw the patient's file at Office Manager A. The file missed hitting her. Office Manager A described the working conditions at the Respondent's practice as "horrible," "toxic," and "unhealthy," with the staff "constantly being told [by the Respondent] that you're stupid."

18. Office Manager A also stated that the Respondent would make inappropriate comments of a personal nature to staff members and often used profanity in the back offices of the practice.

D. Interview of Medical Assistant A

19. On or about June 30, 2020, Board staff interviewed a medical assistant who previously worked at the Respondent's practice ("Medical Assistant A") under oath. Medical Assistant A stated that she worked for the Respondent between March 3, 2019 and April 17, 2019.

20. Medical Assistant A stated that the Respondent told her to enter diagnosis codes in patient records prior to the Respondent seeing the patients. When Medical Assistant A told the Respondent that she did not feel trained to do so, the Respondent told her that if she could not handle doing it, then she needed to look for other employment.

21. Medical Assistant A said that she quit her job at the Respondent's practice because she "felt abused" there. She said that even if a staff member made minor mistakes, the Respondent would yell at them and was "demeaning us in some sort of way." She also said that the Respondent used profanity when she was upset and was "very derogatory and disrespectful." Medical Assistant A described the work environment as "very hostile."

E. Interview of Office Manager B

22. On or about July 15, 2020, Board staff interviewed a former office manager at the Respondent's practice ("Office Manager B") under oath. Office Manager B stated that he worked for the Respondent from February 11, 2020 to April 3, 2020.

23. Office Manager B was present when Board staff performed the unannounced site visit (see ¶ 11, above). He explained that sharps disposal containers were not in each examination room when Board staff arrived, and that the Respondent had a medical assistant place the sharps containers in the rooms while Board staff was waiting. Office Manager B said that prior to Board staff's visit, the sharps containers were kept in only one examination room, so individuals had to walk down hallways with exposed sharps to dispose of them.

24. Office Manager B said that he had observed the Respondent perform a BCG treatment without wearing all of the necessary PPE. According to Office Manager B, the Respondent explained her use of only gloves and a mask by stating that she had performed BCG treatments for years and never contracted tuberculosis.

25. When asked about the overall office environment, Office Manager B said "it was a mess," and the Respondent's use of profanity "was just a little bit much." He believed that patients could overhear the Respondent's use of profanity. He explained that

when the Respondent was upset she would threaten staff by saying things such as, "I'm just going to have to close things down," and "everybody is going to be let go."

F. Prescriptions for Employees

26. The Board obtained information that the Respondent prescribed controlled dangerous substances ("CDS") to at least two of her employees. Based on this information, the Board obtained copies of the prescriptions from the pharmacies where they were filled.

27. On or about July 16, 2018, the Respondent prescribed a Schedule IV CDS to a medical assistant who worked for her ("Medical Assistant B"). The Respondent did not keep records for Medical Assistant B related to this prescription.

28. On at least three occasions over the course of nearly a year the Respondent prescribed a Schedule IV CDS to another medical assistant who worked for her ("Medical Assistant C"). Specifically, on or about December 5, 2017, the Respondent prescribed the CDS with five refills; on or about April 12, 2018, the Respondent prescribed the CDS with four refills; and on or about November 8, 2018, the Respondent prescribed the CDS with five refills. The Respondent did not keep any records for Medical Assistant C related to these prescriptions.

G. Treatment and Prescriptions for Family Member A

29. The Board obtained information that the Respondent was treating and had prescribed CDS to a family member ("Family Member A"). Based on this information, the Board obtained Family Member A's medical records from the Respondent as well as copies of certain CDS prescriptions from the pharmacies where they were filled.

30. The medical records that the Respondent maintained for Family Member A show that the Respondent treated Family Member A for many years. These records further

show that, since 2014, the Respondent provided approximately 13 non-CDS prescriptions to Family Member A.

31. The prescription copies show that the Respondent provided approximately 28 CDS prescriptions to Family Member A in since December 2017. These prescriptions ranged from Schedule II to Schedule IV CDS. The Respondent did not maintain records to support all of the 28 CDS prescriptions.

H. Interview of the Respondent

32. On or about July 23, 2020, Board staff interviewed the Respondent under oath. The Respondent stated that, at the time of the interview, she employed four medical assistants, three who were full-time and one who was part-time.

33. The Respondent explained that the clinical duties for medical assistants in her practice include:

a. Independently changing catheters and doing "in and out catheterization" for urine samples, which entails "cleaning off the penis . . . putting lidocaine gel inside the urethra and then passing the catheter through the urethra into the bladder";

b. Independently irrigating Foley catheters, which consists of instilling approximately 60cc of saline through the catheter, then pulling it back out through the catheter;

c. Independently performing bladder scans;

d. Independently performing the technical components of urodynamic studies (but not interpreting the results), which includes inserting a balloon catheter into the bladder, instilling fluid into the bladder, and monitoring sensors attached to the patient's rectum, among other things; and

e. In the past, independently refilling prescriptions for patients with overactive bladder who had been taking the prescribed medication for a year, although this is not done with the current medical assistants.

34. The Respondent acknowledged that there may have been occasions when a patient called with a catheter problem while the Respondent was in surgery or otherwise out of the office. The Respondent explained that, instead of referring a patient to the emergency room, she would tell the medical assistant in her office to "let [her] know if there's a problem, otherwise just change it."

35. The Respondent said that she allowed a medical assistant who previously worked for her to perform BCG treatments alone, which included inserting a catheter into the patient's bladder, mixing the anticarcinogenic medication, instilling the medication into the bladder, and disposing of the hazardous waste. The Respondent said that she would be on site when the medical assistant performed BCG treatments, but not in the same room.

36. The Respondent also said that when she performs BCG treatments, she wears gloves and a mask. She said, "I've been doing it for over 20 years . . . I've just done it the same way from the beginning of time and I've not had any trouble in doing it that way."

37. Regarding documentation, the Respondent said that medical assistants may enter a diagnosis code into the record before the Respondent sees the patient because they cannot enter certain procedures unless there is a corresponding diagnosis code.

38. The Respondent acknowledged that encounters may remain open for months because the Respondent may have remembered something to add to the record and "moved on" without closing it. The Respondent considers these encounters as "completed." She said there were approximately 300 open encounters at the time of the Board interview. The Respondent could not confirm whether her office submits claims on open encounters but stated that all claims are supported with at least a diagnosis code and reason for visit.

39. The Respondent acknowledged using inappropriate language at Hospital A. She also acknowledged using profanity in an operating room while there was a patient on the operating table, but she believed that the patient was under anesthesia. The Respondent denied directing profanity at staff members in her office but said that she may have been mumbling profanities to herself in the office hallway. She acknowledged that she made inappropriate comments of a personal nature and recognized that such comments made it "not a great environment" for her employees.

40. The Respondent admitted to prescribing CDS to Medical Assistants B and C but not creating a record for those prescriptions. The Respondent said that she would discuss concerns informally with the medical assistants and would prescribe CDS to them following those conversations.

41. The Respondent also admitted to treating and prescribing CDS to Family Member A for many years. She explained that she simply tried to fix Family Member A's flare-ups, acknowledging that she "honestly should not have." She clarified that she was the initial prescriber for certain CDS for Family Member A.

I. Independent Evaluation

42. On or about June 5, 2020, pursuant to the Board's direction, the Respondent underwent an independent medical evaluation to assess her fitness to practice medicine. The Evaluator submitted his report the Board on or about June 22, 2020.

43. Based on the report, the Respondent stated during the evaluation that, among other things, she prescribed CDS to herself and Family Member A. She told the Evaluator that she used another relative's prescribed Schedule II CDS "intermittently," most recently

three-to-four months before the evaluation. She acknowledged that she does not have a primary care physician and orders labs and writes prescriptions for herself.

44. The Evaluator noted that, among other things, the Respondent's pattern of conduct related to prescriptions was "concerning and inappropriate." He concluded that the Respondent "can practice safely, but only with a significant period of mandated monitoring[.]"

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel B concludes as a matter of law that: the Respondent violated Health Occ. § 14-404(a)(3)(ii) by engaging in unprofessional conduct in the practice of medicine; and the Respondent violated Health Occ. § 14-404(a)(18) by practicing medicine with an unauthorized person or aiding an unauthorized person in the practice of medicine. Panel B dismisses the charges under Health Occ. §§ 14-404(a)(11) and (36).

ORDER

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

ORDERED that the Respondent is **REPRIMANDED**; and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum of **TWO (2) YEARS.**[5] 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 ("MPRP") as follows:

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

(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 from MPRP records and files in a public order. The Respondent shall not withdraw his/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 (including all of the Respondent's current therapists and treatment providers) verbal and written information concerning the Respondent and to ensure that MPRP is authorized to receive the medical records of the Respondent, including, but not limited to, mental health and drug or alcohol evaluation and treatment records. The Respondent shall not withdraw his/her release/consent;

(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 Consent Order;

2. Within **SIX (6) MONTHS** from the effective date of this Consent Order, the Respondent is required to take and successfully complete (i) a course in **ethics** and (ii) a course in **workplace 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 courses before the courses are begun;

(b) The disciplinary panel will accept courses taken in-person or over the internet during the state of emergency;

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

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

(e) The Respondent is responsible for the cost of the courses;

3. Within **TWO (2) YEARS** from the effective date of this Consent Order, the Respondent shall pay a civil fine of **FIVE THOUSAND DOLLARS ($5,000)**. 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 the Respondent's license if the Respondent fails to timely pay the fine to the Board; and

4. The disciplinary panel may issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program on a quarterly basis for the Respondent's Controlled Dangerous Substances ("CDS") prescriptions. The administrative subpoenas will request the Respondent's CDS prescriptions from the beginning of each quarter; and it is further

ORDERED that the Respondent shall not apply for early termination of probation; and it is further

ORDERED that, after the Respondent has complied with all terms and conditions of probation and the minimum period of probation imposed by the Consent Order has passed, the Respondent may submit to the Board a written petition for termination of probation. After consideration of the petition, the 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 may 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 relating to the charges; and it is further

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

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

ORDERED that after the appropriate hearing, if the disciplinary panel determines that the Respondent has failed to comply with any term or condition imposed by this Consent Order, the disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke the Respondent's license to practice medicine in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on the Respondent; and it is further

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

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

ORDERED that this Consent Order is a public document. *See* Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6) (2014 & 2019 Supp.).

04/06/2021
Date

Signature on File

Christine A. Farrelly
Executive Director
Maryland Board of Physicians

CONSENT

I, Cynthia J. Moorman, M.D., acknowledge that I have consulted with counsel before signing this document.

By this Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition.

I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 14-405 and Md. Code Ann., State Gov't §§ 10-201 *et seq.* concerning the pending charges. I waive this right and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive protections. I acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order.

I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.

I sign this Consent Order, without reservation, and fully understand the language and meaning of its terms.

Signature on File

3/30/21
Date

Cynthia J. Moorman, M.D.

NOTARY

STATE OF Maryland

CITY / COUNTY OF Frederick

I HEREBY CERTIFY that on this 30 day of March 2021, before me, a Notary Public of the foregoing State and City/County, personally appeared Cynthia J. Moorman, M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

JENNIFER CABRERA
Notary Public-Maryland
Frederick County
My Commission Expires
April 21, 2024

Notary Public

My Commission expires: