IN THE MATTER OF	*	BEFORE THE
JESUS A. BURBANO, M.D.	*	MARYLAND STATE
Respondent	*	BOARD OF PHYSICIANS
License Number: D55094	*	Case Number: 2218-0282A

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of **JESUS A. BURBANO, M.D.** (the "Respondent"), License Number D55094, to practice medicine in the State of Maryland.

Panel A takes such action pursuant to its authority under Md. Code Ann., State Gov't ("State Gov't") § 10-226(c)(2) (2014 Repl. Vol. and 2017 Supp.) and Md. Code Regs. ("COMAR") 10.32.02.08B(7), concluding that the public health, safety or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

Based on information received by, and made known to Panel A, and the investigatory information obtained by, received by and made known to and available to Panel A, including the instances described below, Panel A has reason to believe that the following facts are true:[1]

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[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with reasonable notice of the alleged facts. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

I. BACKGROUND

1. The Respondent was originally licensed to practice medicine in Maryland on July 23,1999, under License Number D55094. The Respondent's latest license was given the expiration date of June 30, 2020.

2. At all times relevant hereto, the Respondent operated a medical practice named *JB Pediatrics and Adolescent Medicine* (the "Practice"), which is located at 8615 Ramsey Avenue, Silver Spring, Maryland 20910.

3. The Respondent is board-certified in pediatric medicine.

II. THE COMPLAINT

4. The Board initiated an investigation of the Respondent after receiving a complaint, dated June 15, 2018, from a physician assistant (the "Complainant")[2] who practiced at an urgent care facility (the "Facility") in the District of Columbia. The Complainant reported that on June 15, 2018, the Respondent entered the Facility at 11:00 a.m. and slept in the Facility's waiting room until 1:00 p.m., when medical assistants there tried to rouse him, without success. The medical assistants asked the Complainant to try to wake up the Respondent. The Complainant administered a sternal rub to the Respondent, who continued snoring through the procedure. The Complainant shook the Respondent, who briefly woke up. The Complainant informed the Respondent that he had to complete paperwork and be seen or the Facility might be forced to transport him to the emergency room for further evaluation. The Respondent agreed but then fell asleep again briefly. The Complainant was forced to wake up the Respondent again.

[2] For confidentiality reasons, the names/identities of the Complainant, medical facilities and other individuals will not be disclosed in this document. The Respondent may obtain the identity of any individual/entity referenced herein by contacting the assigned administrative prosecutor.

5. The Complainant stated that she suspected that the Respondent might be "under the influence." Upon further inquiry, she determined that the Respondent had self-prescribed several benzodiazepine medications (benzodiazepines are a Schedule IV controlled dangerous substance).

6. The Complainant questioned the Respondent further, who claimed that he had not used benzodiazepines that day. The Complainant stated that the Respondent then refused to discuss anything further about his benzodiazepine use and refused to undergo blood tests.

7. Along with her complaint, the Complainant provided the information she obtained to the Board.

III. SUBSEQUENT BOARD INVESTIGATION

8. By letter dated August 14, 2018, the Board requested that the Respondent provide a response to the above complaint.

9. The Respondent provided a written response to the Board in a letter dated August 24, 2018. The Respondent acknowledged that since 2004, several physicians had prescribed benzodiazepines for him to treat medical conditions and he did "on a few occasions obtain benzodiazepines pursuant to [his] own prescription." The Respondent claimed that his objectivity when self-prescribing was not compromised because he was using this medication for nearly fifteen years and only self-prescribed in "emergency" situations when he was not able to obtain prescriptions from his physicians. The Respondent admitted that he "did not create a separate medical record for [himself] related to those [self-prescribing] instances." The Respondent asserted that his self-prescribing of controlled substances was not inconsistent with American Medical

Association guidelines on self-prescribing. The Respondent further stated that he does "not suffer from any addictions or engage in the habitual use of any controlled dangerous substance, and am not otherwise habitually intoxicated."

10. Pursuant to its investigation, the Board obtained the Respondent's medical records from two physicians whom the Respondent identified as his treating physicians.

11. The Board also issued a subpoena to the Prescription Drug Monitoring Program ("PDMP"), reviewed the Respondent's medication profiles from various area pharmacies, and obtained his pharmacy records and prescriptions for controlled dangerous substances for the period beginning on January 1, 2016 until July 11, 2018. The information obtained revealed that since 2008, in addition to medications prescribed by his treating providers, the Respondent self-prescribed benzodiazepines on numerous occasions, normally authorizing four refills per new prescription written. Also, the two physicians the Respondent employed at the Practice (Physician A and Physician B, respectively) intermittently wrote benzodiazepine prescriptions for him. Physician A prescribed for the Respondent from approximately mid-2007 to early-2016 while Physician B prescribed for the Respondent from approximately mid-2012 to mid-2014. The Respondent did not maintain a medical record while self-prescribing nor did the Practice maintain medical records for the prescribing that practitioners there provided for him.

12. After receiving this information, the Board, pursuant to Health Occ. § 14-402(a),[3] referred the Respondent to a Board-approved program (the "Program") for an evaluation. The Program directed him to undergo a neuropsychological evaluation.

13. On or about December 5, 2018, the Board received a comprehensive evaluation report involving the Respondent.[4] The evaluator stated that the Respondent's "current cognitive profile gives rise to significant concerns about his ability to practice at the level expected for a physician." The evaluator concluded that for the reasons stated in his report, the Respondent "should not practice medicine at this time."

14. Based on the above investigative facts, Panel A finds that the Respondent presents a substantial likelihood of a risk of serious harm to the public health, safety and welfare.

CONCLUSIONS OF LAW

Based upon the foregoing Investigative Findings, Panel A of the Board concludes that the public health, safety, or welfare imperatively requires emergency action, and that pursuant to State Gov't § 10-226(c)(2) and COMAR 10.32.02.08B(7), the Respondent's license is summarily suspended.

ORDER

IT IS thus, by Panel A of the Board, hereby:

ORDERED that pursuant to the authority vested in Panel A by State Govt. § 10-226(c)(2)(2014 Repl. Vol. and 2017 Supp.) and COMAR 10.32.02.08B(7), the

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[3] Health Occ. § 14-402(a) states: In reviewing an application for licensure, certification, or registration or in investigation against a licensed physician or any allied health professional regulated by the Board under this title, the Physician Rehabilitation Program may request the Board to direct, or the Board on its own initiative may direct, any physician or any allied health professional regulated by the Board under this title to submit to an appropriate examination.

[4] In order to maintain confidentiality, the details of the comprehensive report will not be disclosed in this Order, but the report will be made available to the Respondent upon request.

Respondent's license to practice medicine in the State of Maryland is hereby **SUMMARILY SUSPENDED;** and it is further

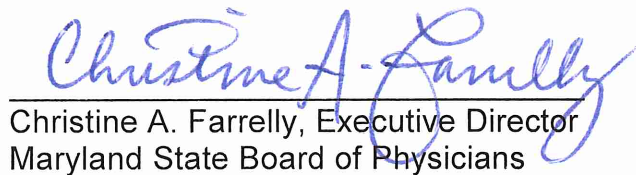
ORDERED that in accordance with Md. Code Regs. 10.32.02.08B(7) and E, a post-deprivation initial hearing on the summary suspension will be held on **Wednesday, January 16, 2019, at 11:15 a.m.** at the Board's offices, located at 4201 Patterson Avenue, Baltimore, Maryland, 21215-0095; and it is further

ORDERED that after the **SUMMARY SUSPENSION** hearing before Panel A, the Respondent, if dissatisfied with the result of the hearing, may request, within ten (10) days, an evidentiary hearing, such hearing to be set within thirty (30) days of the request, before an Administrative Law Judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031-1301; and it is further

ORDERED that a copy of the Order for Summary Suspension shall be filed by Panel A immediately in accordance with Health Occ. § 14-407 (2014 Repl. Vol.); and it is further

ORDERED that this is an Order of Panel A, and as such, is a public document. *See* Health Occ. §§ 1-607, 14-411.1(b)(2) and Md. Code Ann., Gen. Prov. § 4-333(b)(6).

01/02/2019
Date



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