IN THE MATTER OF	*	BEFORE THE MARYLAND
HUGO BENALCAZAR, M.D.	*	STATE BOARD OF
Respondent	*	PHYSICIANS
License Number: D56356	*	Case Number: 2221-0051

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

FINAL DECISION AND ORDER
ON ORDER FOR SUMMARY SUSPENSION
OF LICENSE TO PRACTICE MEDICINE

On July 2, 2021, pursuant to § 10-226(c)(2) of the State Government Article, Md. Code Ann., Disciplinary Panel A of the Maryland State Board of Physicians (the "Board") issued an Order for Summary Suspension of License to Practice Medicine, which immediately suspended Respondent Hugo Benalcazar, M.D.'s license to practice medicine in Maryland. On July 14, 2021, Disciplinary Panel A held a postdeprivation hearing on the summary suspension and, on July 15, 2021, affirmed the summary suspension.

On October 4, 7, and 8, 2021, a contested case, evidentiary hearing was held before an Administrative Law Judge ("ALJ") at the Office of Administrative Hearings ("OAH"). The State presented the following witnesses: a Compliance Analyst of the Board; Complainant 1, a registered nurse; Complainant 2, a surgical technologist; Individual 3, an Operating Room ("O.R.") unit secretary; Individual 4, an O.R. unit secretary; and Individual 9, a physician assistant. The Respondent did not present any testimony or witnesses at the OAH hearing. On December 15, 2021, the ALJ issued a proposed decision recommending that the Order for Summary Suspension be reversed.

Both the State and the Respondent filed exceptions. The State filed exceptions arguing that the ALJ's finding—that any threat that the Respondent may have posed had been

ameliorated by the time the summary suspension was issued—was unsound. The Respondent's exceptions focus on his claim that the ALJ did not properly address his contention that exculpatory evidence was purposely not presented to the Board panel before the panel issued the order summarily suspending his license. Both parties filed a reply to the opposing party's exceptions.

On March 23, 2022, an exceptions hearing was held before Board Disciplinary Panel B ("Panel B" or the "Panel").

I. FINDINGS OF FACT

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

1. The Respondent was originally licensed to practice medicine in Maryland on August 3, 2000. The Respondent continually had his license renewed, and he was authorized to practice medicine in Maryland from August 2000 until his medical license was summarily suspended on July 2, 2021. The conduct of the Respondent that is the focus of this case occurred while he was licensed by the Board. The Respondent is male.

2. The Respondent is board-certified in neurological surgery.

3. The Respondent has practiced neurosurgery, physical therapy, and pain management in Maryland. The Respondent has held privileges at four hospitals in Maryland.

Complainant 1

4. Complainant 1, a female, has been a registered nurse for over 20 years and works in the O.R. as a registered nurse.[1] Complainant 1 worked at a hospital in Maryland (the "Hospital") from May 2004 until October 2018.

[1] The Panel has used generic terms for individuals and facilities where possible in order protect their reasonable expectation of privacy and for patients, their confidentiality. In addition, this case involves issues of sexual harassment and inappropriate sexual conduct, and thus the Panel does its best to keep the names of the victims confidential.

5. In 2013, Complainant 1 was working at the Hospital with the Respondent treating a patient. They were using a 3D navigational system instrument that had silver balls. At the end of the procedure, the balls fell on the floor. Complainant 1 picked up some of them off the floor and put them in the Respondent's pocket. The Respondent then said to Complainant 1, "Why don't you put them in your mouth?" Complainant 1 responded, "[T]hat is gross." Later that day, Complainant 1 was working in a computer area in the Hospital, and the Respondent walked over to her and placed his hand through the V-neck opening of her scrub shirt, and he placed his hand on Complainant 1's chest. He did not touch Complainant 1's breasts.

6. Complainant 1 reported the incidents to the Hospital's perioperative director at the and the two of them had a meeting with the Respondent. The Hospital took no action against the Respondent at this time, and Complainant 1 felt her concerns were not taken seriously by the perioperative director or by the Respondent.

7. The Respondent made other inappropriate comments to Complainant 1, for instance, stating to Complainant 1 that he could see her bra straps and underwear.

Complainant 2

8. Complainant 2, a female, is a surgical technologist. Complainant 2 works at the Hospital. She began working at the Hospital in June 2015.

9. Complainant 2 previously worked in the O.R. with the Respondent two days per week.

10. In 2016, Complainant 2 had lower back pain while she was pregnant. On one occasion, Complainant 2 was in the O.R. and mentioned her pain to one of her colleagues. The Respondent overheard and offered to examine her in between cases. The Respondent escorted her into a Hospital room and closed the door. No one else was in the room. Complainant 2

turned so the Respondent was behind her, so she could point to where the pain was. He asked her to raise her shirt, which she did, about midway up her back. The Respondent placed his hands on her waist and started to feel her lower back with his thumbs while asking her where the pain was. The Respondent then asked her to lower her pants. She lowered her pants about halfway down her buttocks. The Respondent then commented on how good Complainant 2 looked from behind and that her underwear was "very cute." The Respondent was giggling. Complainant 2 felt she was being taken advantage of, so she lifted her pants back up and left the room.

11. When Complainant 2 came back from maternity leave in October 2016, she worked with the Respondent two days per week, Mondays and Wednesdays. She maintained this schedule until May 2017. The Respondent asked her about her sex life with her fiancé and told her that she would have a better time with him than with her fiancé. The Respondent also physically touched her on days that they worked together. The touching was unwanted by Complainant 2. He stroked her neck and massaged it. He also grabbed Complainant's 2's hair and then would use it to turn her head. He showed her pictures of other women wearing risqué Halloween costumes and said that he would love to see her in these costumes. The Respondent physically grabbed Complainant 2 and pulled her close to him. He made comments about her bra. At the scrub sink, the Respondent embraced her from behind. He felt her legs to see whether she had shaved her legs. Complainant 2 testified, "I would describe it as it was a daily occurrence. Every day he physically touched me. He verbally harassed me every day, every shift I was there with him." (T. 239.)

12. On April 19, 2017, Complainant 2 observed the Respondent slap the buttocks of an anesthetized patient ("Patient 1").

13. The Respondent talked about how he could get people fired, which caused Complainant 2 to be afraid to report him. Complainant 2 stated that she asked her supervisors to change her schedule but did not state that it was because of the Respondent. She believed that her supervisors knew the reason that she wanted to change because she had told them many times before about how uncomfortable she was, but the supervisor did not ask for the reason. Ultimately, Complainant 2 was able to get her schedule changed so she did not have to work with the Respondent any longer. On October 16, 2018, Complainant 2 filed a complaint with the Hospital's Human Resources department.

Patient 1

14. On April 19, 2017, a female patient, Patient 1, was in the O.R. and unconscious after being anesthetized. Patient 1 was positioned for a lumbar procedure on her spinal column. Patient 1 was lying on her abdomen, face down, and her buttocks were fully exposed. From her neck to her feet there were no clothes or sheets covering her. The Respondent came into the room and did not like the way a physician assistant had taped the skin of the patient, and the Respondent ripped the tape off the patient. The Respondent made comments about how good Patient 1 looked and that her buttocks looked great. The Respondent then forcefully slapped Patient 1's buttocks, which made a loud noise. The Respondent then sang the verse "Baby Got Back" and was giggling. The Respondent told Individual 9 (a physician assistant) to re-tape the patient. At least three O.R. workers witnessed this incident: Individual 9, Complainant 2, and Individual 5. There was no medical justification for the Respondent to slap the patient's buttocks.

Individual 3

15. Individual 3 is a O.R. unit secretary at the Hospital, and she has worked at the Hospital for 21 years.

16. Individual 3 observed that Complainant 2 had a lot of issues involving the Respondent regarding "offhand, off-color, sexual comments" the Respondent made. Individual 3 witnessed the Respondent and Complainant 2 come out the O.R. after a case and the Respondent glared at Complainant 2 and said to her, "I'd like to put you over my knee and spank you, spank you, spank you." (T. 381.)

17. Individual 3 testified that "[p]eople were a little leery of going to anyone about his behavior because they felt that nothing would be addressed." (T. 382.) Individual 3 further explained, "I think there was -- a lot of people were afraid that with his -- that they would get fired if they tried to bring something to the forefront about him." (*Id.*)

Individual 4

18. Individual 4, a female, began working at the Hospital in 2013. In 2015, Individual 4 began working as an O.R. unit secretary. At the time of the evidentiary hearing, Individual 4 was no longer working at the Hospital. The Respondent often called Individual 4 "Strawberry."

19. One time at work, the Respondent was sitting at a desk close to where Individual 4 was sitting, and the Respondent called Individual 4 on her desk telephone and asked Individual 4 "to sit on his lap." (T. 319.) On another occasion, the Respondent told Individual 4 that, for a skinny girl, she had a "nice butt." (T. 329.)

20. On another occasion, Individual 4 was walking down a Hospital hallway, and the Respondent grabbed her wrist, led her into an office, and closed the door. No one else was in the office. The Respondent then aggressively asked Individual 4 to touch his penis. The

Respondent asked eight times for Individual 4 to touch his penis. She "said no quite a few times." Individual 4 was "petrified." (T. 325.) Individual 4 did manage to leave the office without touching Respondent's penis. Individual 4 told her best friend at work about this incident. Individual 4 also spoke to the Hospital's perioperative director about her concerns about the Respondent, although Individual 4 does not recall how specific she was. Individual 4 did not think her concerns were properly handled by the perioperative director.

21. Individual 4 explained before the ALJ why she had not reported these incidents to the Hospital's Human Resources department: "Fear, knowing that he had said to people before that he, you know, kind of had control over jobs."

22. Individual 4 and the Respondent were never in a romantic relationship together and never had sex with each other, Individual 4 never demanded money from the Respondent, and Individual 4 did not send a racy photograph of herself to the Respondent.

Individual 5

23. Individual 5, a female, worked as a registered nurse at the Hospital. Individual 5 worked in the O.R. with the Respondent when she worked at the Hospital. Individual 5 now works at a surgery center at another facility.

24. In April 2017, Individual 5 observed the Respondent slap the buttocks of Patient 1. Individual 5 noticed that everyone who saw him slap the patient looked shocked. Individual 5 was interviewed by Board staff and said, "You know, that's not typical behavior of a surgeon, at least not a good one, and I do remember reporting it." Individual 5 reported the incident to the charge nurse, but stated, "And I don't know that anything after that point was ever done." (State's Ex. 15, T. 10.)

25. Working in the O.R with the Respondent was impairing for Individual 5. Individual 5 explained:

> I don't want to say it impairs you 100 percent, but you definitely are – are impaired, because you're also worried about how you have to avoid another conversation with a surgeon – which is impossible to avoid when you're working in a surgical area like that, because you need to talk to him, you need to have open communication, and you kind of have to forget those things happened, and treat every day like a new day, and that's really difficult when you do experience things and know things that have happened.

Individual 6

26. Individual 6, a female, worked at the Hospital as a neuromonitoring tech for approximately two years, from 2015 to 2017.

27. The Respondent tried to give Individual 6 a neck massage at least twice.

Individual 9

28. Individual 9 is a surgical physician assistant for surgery. He has been a physician assistant since 1993. Individual 9 was employed by the Respondent from July 2016 to November 2017. He has worked for the Hospital since December 2017.

29. In April 2017, Individual 9 was in the O.R. with Patient 1, when Patient 1 was anesthetized, and the Respondent came into the room. Individual 9 testified that the Respondent was "slapping [the patient's] rear end and dancing around and saying -- like singing the butt song ["Baby's Got Back"] or whatever." (State's Ex. 7, T. 16.)

30. Individual 9 also observed the Respondent constantly hugging staff, massaging their necks, and asking them about their sex lives.

Proceedings

31. In June 2018, counsel for Complainant 2 sent a letter ("Demand Letter") to the Respondent stating that the Respondent had sexually harassed Complainant 2. The Demand

Letter attached draft filings with the EEOC and a circuit court in Maryland. The Demand Letter asked for five million dollars in exchange for Complainant 2 not filing actions and complaints against the Respondent. The Respondent did not pay Complainant 2.

32. On October 4, 2018, Complainant 2 met with a person from the Hospital's Human Resources department and the Hospital's perioperative director to discuss the Respondent's behavior.

33. In October 12, 2018, Complainant 2 filed a lawsuit in a circuit court in Maryland against the Respondent, the Respondent's private practice, and the Hospital, alleging sexual harassment, assault, battery, and intentional infliction of emotional distress.[2]

34. On October 16, 2018, Complainant 2 filed a formal complainant against the Respondent with the Hospital's Human Resources department.

35. As a result of the lawsuit filed in circuit court, the Hospital's Performance Improvement Committee appointed an Ad Hoc Committee to investigate the allegations in the lawsuit against the Respondent. The Ad Hoc Committee interviewed the Respondent and a number of other individuals involved in the surgical units of the Hospital. The Ad Hoc Committee wrote that it did not consider the incident in which the Respondent slapped the buttocks of Patient 1, because the incident "involved a patient" and thus the Ad Hoc Committee "did not consider this incident to be within the specific scope of its investigation," but the report did state that the Respondent "acknowledged the incident, though he explained it by saying that he was not happy with the way the patient was taped, removed the tape and moved the patient's buttocks." The report also did not reference the incident involving Individual 4 in which the Respondent tried to get her to touch his penis. But the report did mention that two Hospital employees stated that the Respondent put his hands around the neck of a female staff member,

[2] At the time of the evidentiary hearing at OAH, the lawsuit was still ongoing.

and one of those employees stated that the Respondent refused to let go "even when she asked him to." The report further stated that Complainant 2 had not previously reported incidents of inappropriate behavior to the Human Resources department because "she feared losing her job or other repercussions." The report also mentioned that, in addition to Complainant 2, other employees interviewed said that the Hospital O.R. had a culture that was inhospitable to complaints against physicians.

36. On March 6, 2019, the Hospital issued the Respondent a Letter of Reprimand. The Letter of Reprimand stated:

> Based on the investigation, the Ad Hoc Committee, Performance Improvement Committee, and Medical Executive Committee concluded that you had behaved inappropriately towards members of the Hospital staff by inappropriate touching female employees and by making inappropriate comments of a sexual nature to female employees. The Committees felt that you lacked an appreciation for how your behavior was perceived and exercised extremely poor judgment in your lack of appreciation for appropriate boundaries of professional behavior. Your behavior and words were seriously inappropriate.

The Hospital required the Respondent to attend a course in Professional Boundaries and advised the Respondent that his behavior would be "monitored. However, any further reports of this type of unacceptable behavior, at any time in the future, would be reviewed for additional disciplinary action, up to and including termination of medical staff appointment and/or clinical privileges." The Letter of Reprimand further stated that the Letter of Reprimand "will not be reported to the Maryland Board of Physicians" and that "this action does not constitute grounds for a hearing."

37. On August 30, 2020, the Board received a complaint from Complainant 1 (dated August 25, 2020). In her complaint, Complainant 1 alleged that, when she worked with the Respondent at the Hospital, the Respondent behaved inappropriately, both verbally and physically, with Complainant 1 and other female staff members.

38. On November 30, 2020, the Board received two complaints from Complainant 2 against the Respondent. In the first November 30, 2020 complaint (dated November 19, 2020), Complainant 2 described an incident in which the Respondent slapped the buttocks of Patient 1. In the second November 30, 2020 complaint (dated November 19, 2020), she stated that the Respondent was inappropriate when examining her for lower back pain. On December 29, 2020, the Board received a third complaint (dated Nov. 19, 2020) from Complainant 2 against the Respondent, detailing an instance when Complainant 2 was orienting a new surgical technologist at the Hospital and the Respondent stroked her neck. Complainant 2 felt "extremely uncomfortable" and "embarrassed." The complaint also indicated that the Respondent touched her multiple times a day when they worked together, that she did not like it, and that she did not know what to do about it.

39. On July 2, 2021, Disciplinary Panel A of the Board issued the Respondent the Order for Summary Suspension of License to Practice Medicine.

40. The Respondent presented a substantial likelihood of risk of serious harm to the public health, safety and welfare. Thus, the order for summary suspension was imperatively required to protect the public health, safety, and welfare, under State Gov't § 10-226(c)(2).

II. CREDIBILITY

The Respondent did not testify at the OAH hearing, but, on May 21, 2021, and, on May 25, 2021, he was interviewed by Board compliance analysts. When the Respondent was interviewed by the Board's compliance analysts, he denied slapping or spanking Patient 1's buttocks. He said that he was pushing the tissue on her buttocks to show the O.R. staff where to place the frame of a navigational instrument, indicating that the frame should not be placed on fatty tissue where it would be unstable. The Panel does not find his denial credible.

The Respondent's statements have been inconsistent on this matter. The Hospital's Ad Hoc Committee investigation report states that the Respondent "acknowledged the incident, though he explained it by saying that he was not happy with the way the patient was taped, removed the tape and moved the patient's buttocks." Individual 9 also said that the Respondent was upset at how the patient was taped. The Respondent's testimony during his interview with the Board's compliance analysts in which he stated that he was showing the O.R. staff where to place a navigational instrument's frame conflicts with his statement to the Hospital's Ad Hoc Committee.

Moreover, the Respondent's version during his interview is contradicted by three eyewitnesses to the incident: Complainant 2, Individual 5, and Individual 9. (Individual 5 did not testify at the hearing, but she was interviewed by the Board's compliance analysts.) The Panel credits the testimony of Complainant 2, Individual 9, and Individual 5, who each testified that he slapped and/or smacked the patient's buttocks. Individual 9 said the Respondent was "joking around" and sang the verse of "Baby Got Back." (State's Ex. 7, T. 18.) Complainant 2 testified that the Respondent was making comments about how good [Patient 1] looked for her age, that she was in great shape, and that her backside looked great. (T. 247.) Complainant 2 also testified that she was "in complete disbelief." (*Id.*) Individual 5 testified, "it felt extremely unprofessional and that's why I reported it." (State's Ex. 15, T. 12.) There were some differences with the details of the incidents between these three witnesses, but those discrepancies are relatively minor and understandable considering how shocking the Respondent's conduct was to the witnesses.

Concerning Individual 4, when the Respondent was interviewed by the Board compliance analysts, he denied the incident involving Individual 4 in which Individual 4 testified that the

Respondent repeatedly asked her to touch his penis. In fact, when the Respondent was initially interviewed, he initially denied even knowing who Individual 4 was:

> Q. Are you familiar with [Individual 4]?
> [The Respondent] A. No.
> Q. Okay. She was an OR – or she is an OR secretary at [the Hospital]. You have no recollection of her, [Individual 4]?
> [COUNSEL FOR THE RESPONDENT]: [Spells the last name of Individual 4]?
> [COMPLIANCE ANALYST]: Correct.
> [COMPLIANCE ANALYST]: [Blank in transcript]
> [The Respondent] A. I don't.
> Q. Okay. [Individual 4] reported that she changed her schedule at [the Hospital] in order to avoid you after you began bringing her coffee, started calling her by the name Strawberry, commenting on her body and clothes and again texting and calling her personnel cell phone. Do you have any – can you respond to that, or you have no recollection of who she is?
> A. No. I do – I do recall that we had a – again, a playful relationship there which I thought was mutual.
> Q. Okay. She stated that she told you that it made her uncomfortable, asked you to stop bringing her coffee and began wearing jackets to avoid your comments. Were you bringing her coffee?
> A. I have very little recollection of this but certainly possible that that would be the case. And if anyone asked me to stop bringing them coffee, I would stop bringing them coffee.
> * * *
> Q. Okay. And you don't remember anybody that you would call by the nickname Strawberry?
> A. No. I do – I do recall that. I called her that once because her hair was red.
> Q. Okay.
> A. And I said your hair looks like a strawberry.
> Q. Okay. And do you remember if that was [Individual 4]?
> A. I don't remember.
> Q. Okay.
> A. I don't remember the name.

(State's Ex. 19, T. 58-61.)

After the interview, however, counsel for the Respondent contacted a Board compliance analyst and said that after the Respondent had time to reflect on the interview, he was able to recall additional important information regarding Individual 4. A second interview, therefore,

was held four days after the first. At the second interview, the Respondent provided the following testimony:

> The, other person was [Individual 4] and [Individual 4], you know, first of all, the allegation, never happened, never, I didn't understand that whole thing at all, but there is more to [Individual 4] that's very important, again, for context.
>
> [Individual 4], I, I would bring coffee to [Individual 4]. I didn't know what kind of coffee she liked, you know, and people are very particular about their coffee, so [Individual 4] would tell me what coffee she wanted. This isn't something where I'm forcing coffee on someone.
>
> And that sort of sparked a friendly relationship at the hospital and that friendly relationship morphed into a romantic relationship outside of the hospital.
>
> And on one occasion she drove to my administrative office, which is about a mile or so away from the hospital, after hours, specifically to have an encounter with me. She drove her own car, you know, I wasn't there with her.
>
> And, and that lasted a very short time, but the reason that it ended was strictly on – I ended it. And the reason it ended was because she made a demand for money to me and that, you know, freaked me out. I was extremely concerned, obviously, because there was no talk of that at all.
>
> And obviously it is an implied threat to me, and so, and so that's how it ended.
>
> * * *
>
> Q. But you had a sexual relationship with her?
> [The Respondent] A. We had a romantic relationship, yes.
> Q. Okay. And when you say romantic, was there sexual intercourse?
> A. Well, yes, there was.
> Q. Okay.
> A. The one time.
>
> * * *
>
> Q. Mm-hmm. And how did she end up coming to the office?
> A. Oh, I, probably I invited her there.

(State's Ex. 20, T. 6-10.) The Respondent then said there was no specific amount of money that was requested by Individual 4. The Respondent then testified that he communicated with Individual 4 by phone, by text, and by Snapchat. Later in the interview, the discussion turned back to the first interview when he denied knowing who Individual 4 was:

> [BOARD COMPLIANCE ANALYST]: I guess you're talking about someone that you had sex with that threatened you and we, you know,

gave some reference to and that you didn't remember it on Friday, that's what I'm just kind of confused about.

[THE RESPONDENT]: Yeah; no, I, it's not that I didn't remember it, it's that I couldn't, I have to put some kind of coherent thing together, you know, for you guys.

I have to – you want the whole truth and, you know, I, I probably should have asked for a break or something like that, but the next thing I know we were ending and my mind was, you know, running around all over the place.

So, you know, [Individual 4] is not a name I used and so that threw me off, the allegation is barbarous and untrue and threw me off.

So, yeah, this isn't like I had forgot this person, but it is something where if I started talking at that moment, I don't think I could have put, put two and two together. And I didn't want to do that, so.

And there is one other thing, too, and that is that, that this person sent me a picture of herself which is, let's just say, highly suggestive and, again, I just want to underscore the sort of consenting mutual aspect of the relationship.

BY [BOARD COMPLIANCE ANALYST]

Q. When did she send you a suggestive picture?

A. Pretty much right before she – my best recollection is pretty much right before she asked me for the money.

Q. And I know it's been awhile, do you have any proof of her asking for the money or anything like that?

A. I don't think I have any proof of her asking for the money, but I do have the picture that she sent.

(State's Exhibit 20, T. 13-14.)

At the evidentiary hearing before the ALJ, Individual 4 testified. Individual 4 testified that she had not been in a relationship with the Respondent, that she had not had sex with him, and did not ask him for money. On cross examination, Individual 4 did state that she had had a traumatic brain injury and thus could not be 100 percent positive of her recollections, but that she did not have any recollection of a relationship, sex, or money discussions with the Respondent. On cross examination, she was shown the racy photograph. Individual 4 acknowledged that the photograph was of her but said that she did not send it to the Respondent. She testified that she and an anesthesiologist at the Hospital sent photographs to each other. On redirect, Individual 4 was asked about how the photograph could have come into the possession of the Respondent:

> Q. Now, just to clarify, do you know how Dr. Benalcazar would have come into possession of that picture of you?
> [Individual 4] A. Like I said, the only reasonable explanation I can come up with is that someone else showed him, gave it to him. I'm not – that's the only reasonable explanation I have.

(T. 371-72.)

The Panel does not find the Respondent's testimony regarding Individual 4 trustworthy. When he was initially interviewed by the Board compliance analysts, he denied even knowing who Individual 4 was. When he was interviewed the second time, he explained that he had not forgotten who Individual 4 was when he was asked about her in the first interview, but he was not about to "put some kind of coherent thing together." He further said, "So, yeah, this isn't like I had forgot this person, but it is something where if I started talking at that moment, I don't think I could have put, put two and two together. And I didn't want to do that, so." The Panel finds that the Respondent simply lied to the Board compliance analysts. At first, he denied even knowing who she was, and then four days later he stated that he had a romantic relationship with her, had sex with her, that she threatened him for money, and that he has a racy photograph of her. The extent to which he deliberately gave false statements to the Board compliance analysts indicates that his statements are not reliable. The Panel finds that the Respondent is not credible. The evidence in this case does not indicate that he had sexual intercourse with Individual 4, does not indicate that she demanded money from him, and does not indicate that she sent him the racy photograph. The Panel cannot find that Individual 4 fabricated information when she was interviewed or testified before the ALJ. In determining which of these two individuals the Panel relies upon, the only reasonable determination is to believe Individual 4 over the Respondent. The Panel finds Individual 4's testimony credible.

III. EXCEPTIONS

1. STATE'S EXCEPTIONS

A. Whether the Respondent Posed a Continuing Danger Requiring the Order for Summary Suspension

The State took exception to the ALJ's finding that the Respondent did not pose a danger at the time the order for summary suspension was issued. The crux of the ALJ's decision is that any real danger the Respondent may have posed had disappeared by the time the order for summary suspension was issued. The ALJ found that there is no evidence of the Respondent's misconduct after he was issued a Letter of Reprimand from the Hospital, demonstrating, to the ALJ, that the Letter of Reprimand by the Hospital was sufficient to suppress any threat of serious harmful conduct by the Respondent. There are, however, a number of flaws in the ALJ's proposed finding.

To support the finding that the order for summary suspension was not imperatively required, the ALJ attempted to distinguish the *Mullan* case. *Board of Physician Quality Assurance v. Mullan,* 381 Md. 157, 173 (2004). In *Mullan,* the Board summarily suspended the license of a pediatrician, Dr. Mullan, because Dr. Mullan treated patients while intoxicated. *Id.* at 161. The Court of Appeals affirmed the summary suspension. *Id.* at 173. The ALJ's reasoning in the Respondent's case was that no new allegations of wrongdoing after the Letter of Reprimand was issued demonstrated no continuing danger. The ALJ contrasted that to *Mullan,* finding that, in *Mullan,* unlike in the Respondent's case, "there was no evidence that the situation had been ameliorated in any way." (ALJ's Proposed Decision ("PD") at 13.) In *Mullan,* however, there was only one episode of proven wrongdoing, which was that, on one day, April 10, 2000, Dr. Mullan treated patients while intoxicated. There were no complaints of Dr. Mullan treating patients while intoxicated other than the one complaint about April 10, 2000, which

actually led the Court of Special Appeals to "reverse[ ] the Board's finding that summary suspension was 'imperatively required.'" *Mullan,* 381 Md. at 162.

The approach taken by the Court of Special Appeals was the same taken by the ALJ in the Respondent's case. The Court of Special Appeals had found that the lack of complaints between complaint to the Board and the order to summarily suspend "vitiated" any evidence that the order for summary suspension was imperatively required. *Mullan,* 381 Md. at 161-62. The Court of Appeals, in *Mullan,* then reversed the Court of Special Appeals, rejecting the reasoning of the Court of Special Appeals. *Id.* at 173. Thus, *Mullan* specifically rejects the approach and reasoning applied by the ALJ in the Respondent's case.

The Court of Appeals, in *Mullan,* explained why Dr. Mullan continued to pose a danger requiring order for summary suspension despite there being only one day in which it was proven that he saw patients while intoxicated:

> When a pediatrician, with a history of severe alcoholism, renders medical care to children while visibly intoxicated, he exhibits a remarkable lack of sound judgment by his failure to decide not to see patients on that day, even if he could not refrain from using alcohol. Such a lack of sound judgment is sufficient evidence for a reasonable Board to conclude the incident might repeat itself, requiring immediate suspension of the doctor's license and posing a danger that imperatively requires emergency action.

Mullan, 381 Md. at 173. The Respondent demonstrated his remarkable lack of sound judgment by his long-term sexual harassment and offensive touching.

The real difference between *Mullan* and the Respondent's case is that *Mullan* demonstrated his poor judgment on one day, while the Respondent's deleterious behavior and remarkable lack of sound judgment at the Hospital was evident on numerous occasions over the course of years.

Additionally, the Respondent's egregious, long-term behavior was a real distraction to the medical professionals at the Hospital, jeopardizing the health, safety, and welfare of patients in the Hospital. The Respondent jeopardized patient care because he degraded the Hospital environment by being a distraction from the focus that is supposed to be on the practice of medicine, and he impaired the "teamwork approach of health care in the which requires participation from a variety of hospital personnel in order to deliver effective patient care." *Board of Physician Quality Assurance v. Banks,* 354 Md. 59, 75 (1999). The medical professionals working with him on neurosurgery cases in the O.R. should be entirely focused on the medical case, and should not have to worry about protecting themselves and the patients from the Respondent's improper behavior. Individual 5 described the negative effect the Respondent had:

> So, you know, your focus is just making sure that the patient is going to come out okay and it definitely --I don't want to say it impairs you 100 percent, but you definitely are – are impaired, because you're also worried about how you have to avoid another conversation with a surgeon – which is impossible to avoid when you're working in a surgical area like that, because you need to talk to him, you need to have open communication, and you kind of have to forget those things happened, and treat every day like a new day, and that's really difficult when you do experience things and know things that have happened.

(State's Ex. 15 at 33.)

And when the Respondent slapped Patient 1's buttocks while she was completely defenseless and when he pulled Individual 4 into a room and tried to make her touch his penis, the Respondent demonstrated a mindset so depraved that the Panel finds that, at the time the order for summary suspension was issued, there was a strong likelihood that this type of conduct would be repeated. The record does not show that the Respondent's mindset, which led him to act in the manner he did against Patient 1 and Individual 4, had been improved to any significant

degree, which made him a continuing threat to cause serious harm, requiring the order for summary suspension.[3]

The Panel finds that the ALJ placed far too much weight on the lack of additional reports of misconduct occurring after the Letter of Reprimand, especially because the ALJ did not take into account that the Hospital was disinclined to forcefully act on employee complaints brought to its attention against the Respondent. It was only after allegations against the Respondent's conduct became a lawsuit, filed by Complainant 2 in circuit court against the Respondent and the Hospital, that the Hospital moved to address his behavior. Complainant 1 thought that the Hospital did not take her complaints against the Respondent seriously. (T. 39-40.) This was also expressed by Complainant 2. (T. 250.) Individual 4 did not believe her concerns about the Respondent were properly handled by the Hospital's perioperative director. Individual 5 reported the Respondent's behavior to the charge nurse, and she testified, "where it went from there, I don't know." (Ex. 15 at 36.) Individual 5 complained to the Hospital about the Respondent, and she "was pretty much told to – to shut up and leave it alone . . . that there was nothing we could do to – to really fix the situation at hand." (Ex. 15 at 31.) And it is most likely that the Hospital's lenient handling of the Respondent imparted upon the Hospital employees that the Hospital would not provide protection against the Respondent, further discouraging complaints against him. In sum, the environment at, and lack of strong action by, the Hospital

[3] The Panel also certainly does not accept the ALJ's statement that a dangerous situation may not have ever existed. The ALJ wrote, "There was no evidence before the Board that a dangerous situation, *if one ever existed,* continued at the time of the Order for Summary Suspension. (PD at 13) (italics added). There, however, were three eyewitnesses, at least, to Respondent slapping the buttocks of Patient 1 while she was anesthetized. Patient 1 was slapped on her buttocks for no medical reason. When the Respondent attempted to have a hospital employee touch his penis, this was actual harm. The Panel does not accept the ALJ's suggestion that there may never have been a danger. There already was serious actual harm with actual victims.

certainly left the impression that any complaints against the Respondent would not result in action that would properly address his conduct.

Even more, employees felt there could be retaliation against them for complaining about the Respondent. This was expressed by Individual 3, Individual 4, and Complainant 2. Complainant 2 felt there would have been a "target on [her] back" if she made these complaints to the Hospital. In her interview, Complainant 2 stated that the Respondent "would mention how he could get [Individual 5] fired." (Ex. 5 at 8.) And the Respondent did his part to impart upon Hospital personnel that he would retaliate against those who complained about him. Individual 3 testified that the Hospital personnel were afraid to report him, because they felt he could get them fired.

The incident in which the Respondent's slapped Patient 1's buttocks also militates against placing too much weight on the lack of complaints after the Letter of Reprimand. Here, the Respondent demonstrated that he is not above abusing someone who was not conscious. If he engaged in this type of conduct again against someone who was not conscious and there was no one else present to observe, it would not have been reported.

The Panel rejects the ALJ's conclusion that the lack of complaints after the Hospital issued the Letter of Reprimand meant that the Respondent's conduct had been ameliorated. The Panel gives minimal weight to the lack of further allegations after the Letter of Reprimand. The lack of further allegations after the Letter of Reprimand does not convince the Panel that the Respondent no longer presented a significant risk of serious harm to the public health, safety, and welfare.

The Respondent continued to be a serious danger when the order for summary suspension was issued due to his astonishing lack of sound judgment, his utter lack of boundaries, the

distraction he caused at the Hospital, and the seriousness of his egregious behavior. The ALJ's proposed finding that there was no real danger at the time the Order for Summary Suspension was issued is rejected by the Panel. The State's exception is granted.

B. Articulation of Theory for Summary Suspension

The ALJ found that the Board did not articulate a theory in the order for summary suspension stating how the Respondent posed a serious risk of harm at the time the order for summary suspension was issued. (PD at 10-11.) The State took exception.

The ALJ's proposed decision states, "While the Board detailed its Investigative Findings in the Order for Summary Suspension, nowhere did it explicitly state in what way the Respondent's alleged behavior would form the grounds for a revocation under section 14-404 of the Health Occupations Article of the Maryland Code." (PD at 10.) The order for summary suspension, however, does not concern a revocation under § 14-404 of the Health Occupations Article. The summary suspension was based upon § 10-226(c)(2) of the State Government Article, which requires the agency to give the licensee "written notice of the suspension, the finding, and the reasons that support the finding." State Gov't § 10-226(c)(2)(ii)1. The order for summary suspension notified the Respondent of the suspension, stating that "the Respondent's license to practice medicine in the State of Maryland, is hereby **SUMMARILY SUSPENDED**." (Capitals and bold in original.) The order for summary suspension provided the finding, stating "Based upon the foregoing Investigative Findings, Panel A concludes as a matter of law that the public health, safety or welfare imperatively requires emergency action in this case, pursuant to Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol. & 2020 Supp.) and Md. Code Regs. (COMAR") 10.32.02.08B(7)(a)." The order for summary suspension also provided the reasoning upon which the finding of the imperative need for the summary suspension was based:

> 9. The Board's investigation determined that for a period of several years, the Respondent engaged in a pattern of unprofessional conduct that included, but was not limited to, sexual harassment of hospital staff, both verbal and physical, sexual propositioning, and unconsented-to physical contact of at least one patient. The Respondent's conduct proceeded largely unchecked over a period of time due in-part to staff members' perceptions that any complaints about his conduct would not be acted upon at the organizational level.

The order for summary suspension then detailed over the next seven pages the specific alleged facts supporting the order's reasoning as to why the summary suspension was imperative. Based on the order for summary suspension, it is clear that the reason the summary suspension was imperative was because the Respondent's long-term conduct at the Hospital was so outrageous, so menacing and deleterious, and so outside the bounds of appropriate hospital behavior that he persisted as a serious danger. The Panel finds this a reasonable understanding of the order of summary suspension. And Panel B agrees with, and accepts, this reason. The ALJ may not have agreed with it, but that does not mean that the order for summary suspension was deficient. The ALJ erred. The State's exception is granted.

C. Length of Time of Investigation

As to when an agency issues an order for summary suspension, if the agency chooses to issue such an order, is left to the discretion of the agency. *Mullan,* 381 Md. at 168. The ALJ inferred that the issuance of the summary suspension was an abuse of the panel's discretion, because the order of summary suspension was issued 10 months after the Board received the first complaint against the Respondent. The State took exception.

An abuse of discretion is established if no reasonable person would take the same action that was taken by the agency. *See Sibly v. Doe,* 227 Md. App. 645, 658 (2016). The burden of demonstrating an abuse of discretion is on the one challenging the discretionary action taken by

the agency. *See State v. Brown,* 355 Md. 89, 98 (1999). The ALJ's analysis for finding an inference of an abuse of discretion was as follows:

> The length of delay here, from the first complaint filed with the Board on August 30, 2020, to the date of suspension, July 2, 2021, was ten months. While there is no allegation that the Respondent in any way contributed to this delay, the COVID-19 pandemic certainly must have. Nevertheless, the Board was able to interview witnesses and meet remotely, giving rise to the inference that suspending summarily based on an allegation that it was imperatively required was an abuse of the Board's discretion.

(PD at 12.) Essentially, the ALJ established a 10-month deadline for the issuance of an order for summary suspension after an agency receives a complaint against a licensee, indicating that the ALJ believed that a 10-month investigation is just too long. The ALJ erred.

The ALJ's creation of a 10-month deadline was without regard to the circumstances of the case and the investigation needed. The ALJ's analysis is devoid of any facts or information about the investigation, other than it took 10 months to issue the order for summary suspension from the date of the first complaint. The ALJ did not consider the nature or complexity of the investigation or the amount of material involved or any of the numerous reasons that might explain the investigation period (other than the investigation taking place during the COVID-19 pandemic).[4] The ALJ also did not consider whether the Respondent was prejudiced by the length of the investigation, in contravention of the caselaw set forth in *Mullan.* 381 Md. at 169. As articulated by the Court of Appeals, there simply has to be more than just the length of the investigation to support the finding that the issuance of the order for summary suspension was arbitrary or capricious. *Mullan,* 381 Md. At 170 (quoting *State v. Chavis,* 261 S.C. 408, 200

[4] The ALJ also calculated the 10-month period from the date the Board received the first complaint. But there were three complaints that the Board received later. Two were received three months after the first complaint and another was received four months after the first complaint. It does not make sense to the Panel to impose a 10-month deadline and not factor in the Board receiving three more complaints months after receiving the first complaint.

S.E.2d 390, 392 (1973) ("when 'there is nothing other than an unexplained delay on the part of reporting officials, unaccompanied by any showing of prejudice to the driver, the driver is not entitled to any relief because of a delay in imposing the suspension. . . .'") The ALJ's analysis does not comport with the vast discretion expressly afforded agencies investigating potential summary suspension cases: "When investigating potential summary suspensions, an agency should not compromise the thoroughness of its investigation because of the threat of judicial reversal should the investigation take 'too long.'" *Id.*

It is also significant that the *Mullan* decision cites a New York board case in which the summary suspension was upheld despite the investigation taking six years. *See Mullan,* 381 Md. at 170 (citing *John P. v. Axelord,* 97 A.D.2d 950, 468 N.Y.S.2d 951-53 (N.Y.App.Div. 1983)). And the Board has summarily suspended a physician's license after seven years from when the Board received the first complaint against the physician and six years after receiving the second complaint. *Roane v. Maryland Board of Physicians,* 213 Md. App. 619 (2013). The Panel does not accept the ALJ's finding or inference that the order for summary suspension was an abuse of discretion simply because the investigation took 10 months. The ALJ's proposed decision does not set forth any basis for concluding that the order for summary suspension was an abuse of the panel's discretion. *See Mullan,* 381 Md. at 168-73. The State's exception is granted.

2. RESPONDENT'S EXCEPTIONS

The Respondent argues that the Board violated the Respondent's due process rights. The Respondent claims that the Board staff withheld exculpatory evidence from the disciplinary panel at the time the panel voted to issue the order for summary suspension. The Respondent contends that the Board's staff either did not obtain, or purposely kept away, exculpatory

material, such as the Demand Letter, from the disciplinary panel because the material was, or would have been, "inconsistent with their theory of the case."

The first question is whether the Respondent possessed due process rights prior to the issuance of the order for summary suspension. The Respondent argues, "cross examination and the ability to present evidence was not afforded to the Respondent." The Respondent quotes *Travers v. Baltimore Police Dep't*: "a 'basic tenet of fairness in administrative adjudications is the requirement of an opportunity for reasonable cross-examination.'" 115 Md. App. 395, 417 (1997). *Travers'* guidance on cross-examination, however, pertained to the evidentiary hearing, not to the investigation stage. The appellant in *Travers* argued that the admission of hearsay evidence during the evidentiary hearing violated his due process right to cross examination. But the *Travers* court ruled that the right to cross examine was not violated, because the appellant had the opportunity to subpoena the witnesses to testify at the evidentiary hearing but did not do so. *Id.* at 418. Moreover, in *Rosov v. Maryland Bd. of Dental Exam'rs,* 163 Md. App. 98, 115 (2005), the court explained that 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.'" *Travers* does not convince the Panel that the right to cross examine applies during an agency's investigation prior to the issuance of the order for summary suspension.

It may be the case that the Respondent's due process rights could have been violated if the Board's actions during the investigation and prior to the issuance of the order for summary suspension compromised the evidentiary hearing to such an extent that the Respondent was deprived of a fair evidentiary hearing. It does not appear to the Panel that the Respondent made such an argument, but, even if he had, the Panel does not find that the Board staff's actions

impaired the Respondent's due process rights. The Respondent claims that Board staff purposely withheld exculpatory material, specifically the "Demand Letter" (Resp.'s Ex. 7), from the panel that issued the order for summary suspension. But the investigative material contained the fact that Complainant 2 asked for $5,000,000 in exchange for her not pursuing actions against the Respondent. (State's Ex. 19 at 3, T. 9; State's Ex. 26 at 7.) And the Respondent entered the Demand Letter into evidence at the hearing before the ALJ (R. 174), and counsel for the Respondent cross examined Complainant 2 about the Demand Letter. (T. 292-303.) The Panel does not find any intent to keep exculpatory information away from the panel that issued the summary suspension.

Furthermore, the concern that the Respondent has expressed over the information before the disciplinary panel at, or prior, to the issuance of the order for summary suspension, is addressed by the post-deprivation hearing that is promptly held before a disciplinary panel after the order for summary suspension is issued. Under COMAR 10.32.02.08B(7)(c), "[t]he respondent is provided with a postdeprivation opportunity to be heard within 15 days by the disciplinary panel, that voted to summarily suspend the license." If the panel affirms the summary suspension after the postdeprivation hearing, the Respondent has the right to a full evidentiary hearing before an ALJ. The order for summary suspension was issued on July 2, 2021, and the postdeprivation hearing was held on July 15, 2021. At the postdeprivatrion hearing, the Respondent had the opportunity to present his concerns about the summary suspension, including presenting to the panel any relevant information he felt the panel should have been apprised of.

Moreover, the significance of the Demand Letter in this case is not as consequential as the Respondent argues. The Panel is aware that Complainant 2 has a financial stake in her

lawsuit, which could diminish her credibility. The Panel also understands that the Demand Letter offered a deal that in exchange for $5,000,000 Complainant 2 would not file the lawsuit or report the Respondent to various entities and agencies with jurisdiction over the Respondent, which could indicate that Complainant 2 places a large sum of money for herself above her interest in protecting others, which could also diminish her credibility. But the analysis does not stop there. The Panel also must look at other indicators that weigh on her credibility, such as whether her testimony is corroborated by, or conflicts with, the testimony and statements of others. Complainant 2's testimony was extensively corroborated by other witnesses. For instance, Complainant 2's testimony that the Respondent slapped an anesthetized patient's buttocks was corroborated by Individuals 5 and 9; Individual 3 corroborated Complainant 2's testimony that the Respondent made demeaning sexual comments to Complainant 2, such as saying to Complainant 2, "I'd like to put you over my knee and spank you, spank you, spank you"; and Individual 6 alleged that the Respondent tried to massage her [Individual 6's] neck, like Complainant 2 testified that the Respondent massaged her [Complainant 2's] neck. Considering the extent to which Complainant 2's testimony was corroborated, the Demand Letter does not undermine Complainant 2's testimony to any significant degree.

The Respondent also argues that the Board initially did not interview the Hospital's perioperative director, because, "from the investigator's perspective, the investigator knew or had reason to believe that the account provided by the witness was already known." (Resp.'s Exceptions at 8.) During the investigation, Respondent's counsel asked the Board to interview the perioperative director. (Resp.'s Ex. 6.) Board staff then interviewed the perioperative director. Neither party, however, offered the interview transcript into evidence or subpoenaed the

perioperative director to testify.[5] At the evidentiary hearing before the ALJ, the Respondent had the opportunity to subpoena any witness he felt would help his position. OAH has extensive procedures furnishing parties with the power to subpoena witnesses. Upon request of a party, OAH may issue subpoenas requiring the attendance and testimony of witnesses. COMAR 28.02.01.14A. Likewise, an ALJ may authorize the issuance of a subpoena pursuant to § 9-1605(c)(1) of the State Government Article. Under § 9-1605(d)(2), an ALJ may apply to a circuit court to enforce a subpoena. Under COMAR 28.02.01.14F, "If a person fails to comply with a properly served subpoena, at the request of an administrative law judge, the Office may apply to the appropriate circuit court for an order to show cause why the person should not be committed to jail for refusal to comply with a subpoena." Therefore, even if due process rights attached to evidentiary hearings could be tied to the Board's actions during the investigation stage, the record does not indicate that the Respondent's evidentiary hearing process rights were affected by the Board's actions during the investigation stage. The Respondent's exceptions are denied, and the Panel does not adopt the ALJ's proposed decision.

IV. CONCLUSIONS OF LAW

Panel B concludes that the order, issued on July 2, 2021, pursuant to § 10-226(c)(2) of the State Government Article, which summarily suspended the Respondent's license to practice medicine in Maryland was imperatively required to protect the public health, safety, and welfare.

ORDER

It is, thus, by an affirmative vote of a majority of the Board Disciplinary Panel B members present,[6] hereby

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[5] During closing arguments, however, the ALJ stated that, because the transcript of the interview of the perioperative director was on the computer disk (Respondent's Ex. 3) containing the Board's investigative file, "Then it is in evidence." (T. 443.)

[6] Panel B had a quorum at the time it voted.

ORDERED that the Order for Summary Suspension of License to Practice Medicine, issued on July 2, 2021, against the license of Respondent Hugo Benalcazar, M.D. to practice medicine in Maryland, and the order, issued on July 15, 2021, affirming the order for summary suspension, are **AFFIRMED;** and, thus, it is further

ORDERED that the license of the Respondent to practice medicine in Maryland remains **SUSPENDED,** and thus, while the Respondent's license is suspended, the Respondent shall not practice medicine in Maryland; and it is further

ORDERED that this final decision and order is a public document.

08/01/2022
Date

Signature On File

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 in court 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 that it was issued. 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. Also, a copy of the petition for judicial review should be sent to the Maryland Board of Physicians, 4201 Patterson Avenue, Baltimore,

Maryland 21215. 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 and by email at david.wagner@maryland.gov 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.