

IN THE MATTER OF	*	BEFORE THE
RAVINDER DAHIYA, M.D.	*	MARYLAND STATE
Respondent	*	BOARD OF PHYSICIANS
License Number: D61781	*	Case Number: 2219-0083 A

* * * * *

CONSENT ORDER

On April 22, 2020, Disciplinary Panel A (“Panel A”) of the Maryland State Board of Physicians (the “Board”) charged **RAVINDER DAHIYA, M.D.** (the “Respondent”), License Number D61781, under the Maryland Medical Practice Act (the “Act”), Md. Code Ann., Health Occ. (“Health Occ.”) §§ 14-101 *et seq.* (2014 Repl. Vol. & 2019 Supp.).

The pertinent provisions of the Act under Health Occ. provide the following:

§ 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[.]

On August 12, 2020, Panel A was convened as a Disciplinary Committee for Case Resolution (“DCCR”) in this matter. Based on negotiations occurring as a result of this

DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, Order, and Consent.

FINDINGS OF FACT

1. At all relevant times, the Respondent was and is licensed to practice medicine in the State of Maryland. The Board initially issued the Respondent a license to practice medicine in Maryland on May 24, 2004, under License Number D61781. His license is active through September 30, 2020. He is also licensed in Virginia.

2. The Respondent is certified by the American Board of Otolaryngology-Head and Neck Surgery and is certified by the American Board of Facial Plastic and Reconstructive Surgery and the American Academy of Facial Plastic and Reconstructive Surgery.

3. The Respondent owns a plastic surgery and laser center in Rockville, Maryland.¹ He is also a medical director at two aesthetic centers, in Columbia, Maryland and Tysons, Virginia, and has privileges at one Maryland hospital.

4. The aesthetic center in Columbia, Maryland (the "Facility"), offers a variety of services and treatments including non-surgical facial enhancement treatments where dermal fillers and/or neurotoxins are injected into the skin (collectively referred to as "injectables").

¹ The names of facilities and individuals in this document are confidential. The Respondent may obtain the names upon request to the Administrative Prosecutor.

I. The Complaint

5. On October 24, 2018, the Board received an anonymous complaint that alleged that the Respondent was using expired injectables, selling expired products and not supervising staff at the Facility (the “Complaint”).

II. Board Investigation

6. The Board opened an investigation into the Complaint. In furtherance of the investigation, the Board subpoenaed a series of records, notified the Respondent of the investigation, provided the Respondent with the Complaint, requested that the Respondent submit a written response to the Complaint, made a site visit to the Facility and conducted an under oath interview with the Respondent.²

Site Visit of the Facility

7. On March 6, 2019, Board staff conducted a site visit of the Facility and met with the owner of the Facility (the “Owner”) who explained the Facility’s protocol for injectables. The Respondent was not present at the Facility during the site visit.

8. When discussing the protocol for administering the neurotoxin Botox to patients, the Owner explained that the date a Botox vial is reconstituted is written on the vial; all unopened and reconstituted vials are refrigerated; and patient medical records contain the date the patient received Botox, the quantity administered, and the lot number of the Botox vial. The Owner further explained that a reconstituted and refrigerated vial

² On April 12, 2019, the Board received a second anonymous complaint about the Facility alleging a lack of physician supervision and the use and sale of expired products. Because this second complaint contained similar allegations as the Complaint, the Board did not initiate a new investigation and continued to investigate the allegations in both complaints.

of Botox, if not expired, is used on up to six different patients and should last the Facility for three to four weeks.³

9. While at the Facility, Board staff subpoenaed patient logs for appointments and services provided.

10. During the visit, Board staff found expired dermal fillers and local anesthesia, in opened and unopened containers, stored at the Facility.⁴

11. After receiving and reviewing patient logs for appointments and services provided, Board staff subpoenaed patient medical records that documented the use of injectables on patients.

12. The medical records revealed that on October 30, 2018, a patient (the "Patient") at the Facility was injected with an expired dermal filler that had a "use before" date of July 26, 2018. The Patient was injected with a dermal filler over three months after it had expired by a health care practitioner at the Facility, not the Respondent.

The Respondent's Response

13. On March 29, 2019 the Respondent provided a written response to the Board and stated, in pertinent part, that he "made sure that all of the practitioners are adequately trained and supervised" and "with regards to using expired product, I cannot fathom any of the practitioners would even consider doing that."

³ The practice of using a neurotoxin such as Botox on multiple dates and/or patients from a vial marked "single-dose" or "single patient use" was submitted by the Board for expert review and determined to be standard practice and safe, provided standard universal precautions are taken and any refrigeration protocols are followed.

⁴ Board staff were unable to determine if the opened and expired product was used during any patient procedures.

14. The Respondent provided the Board the Facility's written treatment protocol for administering injectables that, in part, instructed, "The product to be used should be checked for the expiration date."

15. On June 19, 2019, Board staff interviewed the Respondent under oath. The Respondent advised that as medical director at the Facility, he is the supervising physician for the nurses and physician assistants who administer injectables. He further advised that he visits the Facility one to three times per month and provides training to the staff.

16. The Respondent also discussed the Facility's practices and procedures regarding injectables and acknowledged that expiration dates should be checked before each use and expired products should not be used on patients. When questioned about the Patient receiving expired dermal filler, the Respondent stated, "Yeah. So that definitely shouldn't happen."

Expert Review

17. On September 13, 2019, the Board submitted records and related materials detailing the use of injectables at the Facility for review by an expert (the "Expert").

18. The Expert is board-certified by the American Board of Plastic Surgery.

19. On November 13, 2019, the Expert submitted a report to the Board where the Expert concluded that the Respondent engaged in unprofessional conduct in the practice of medicine regarding the use of expired injectables. Specifically, the Expert stated:

The use of expired dermal fillers or any other medicine, injectable, filler, etc. is clearly not the standard of care nor standard practice. Each and every time an injection of [injectables] is used, the expiration date should be checked. If expired, this product should not be utilized and discarded.

20. The Expert warned, "The practice of using expired products should be stopped immediately for patient safety."

21. The Expert further opined that the Respondent, in his position as medical director, is responsible for the appropriate and safe administration of injectables at the Facility.

CONCLUSION OF LAW

Based on the foregoing Findings of Fact, Panel A concludes as a matter of law that the Respondent is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii).

ORDER

It is thus by Disciplinary Panel A of the Board, hereby:

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

ORDERED that within **ONE (1) YEAR** of the effective date of this Consent Order, the Respondent shall pay a civil fine of **TWENTY THOUSAND DOLLARS (\$20,000.00)**. The Payment shall be by money order or bank certified check made payable to the Maryland Board of Physicians and mailed to P.O. Box 37217, Baltimore, Maryland 21297. The Board will not renew or reinstate the Respondent's license if the Respondent fails to timely pay the fine to the Board; 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 this Consent Order is a public document. *See* Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6).

Signature on File

02/23/2021

Date

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians

CONSENT

I, Ravinder Dahiya, 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

2/20/21
Date

Ravinder Dahiya, M.D.
Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Prin. County

I HEREBY CERTIFY that on this 20th day of February, 2021, before me, a Notary Public of the foregoing State and City/County, did personally appear Ravinder Dahiya, 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 seal.

02/20/2021

S. J. Vaghela
Notary Public

My commission expires: October 6, 2024

