IN THE MATTER OF	*	BEFORE THE
VITALIS O. OJIEGBE, M.D.	*	MARYLAND STATE BOARD
Respondent	*	OF PHYSICIANS
License Number: D65418	*	Case Number 2219-0113B

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

FINAL DECISION AND ORDER

On July 23, 2019, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") charged Respondent Vitalis O. Ojiegbe, M.D. under the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101—14-702. Specifically, the Respondent was charged with fraudulently or deceptively using a license, Health Occ. § 14-404(a)(2); immoral or unprofessional conduct in the practice of medicine, Health Occ. § 14-404(a)(3)(i) or (ii); professional, physical, or mental incompetence, Health Occ. § 14-404(a)(4); willfully making or filing a false report or record in the practice of medicine, Health Occ. § 14-404(a)(11); making a willful misrepresentation in treatment, Health Occ. § 14-404(a)(17); selling, prescribing, giving away, or administering drugs for illegal or illegitimate medical purposes, Health Occ. § 14-404(a)(27); and willfully making a false representation when seeking or making application for licensure or any other application related to the practice of medicine, Health Occ. § 14-404(a)(36).

The case was forwarded to the Office of Administrative Hearings ("OAH") for an evidentiary hearing. On September 1, 2020, a hearing was held before an Administrative Law Judge ("ALJ") at OAH. The Respondent and the State stipulated that the Charges Under the Maryland Medical Practice Act, issued July 23, 2019, were not contested, except the Respondent contested that he violated Health Occ. § 14-404(a)(4), (17), and (27). The Respondent and the State also stipulated to Joint Exhibits 1 through 70, which were not contested and which were

admitted into evidence. The parties differed as to the appropriate sanction. No witnesses testified at the hearing; however, at the hearing, the peer reviewer for the Board, who wrote a report on the Respondent's prescribing practices, was accepted as an expert in pain medicine. Likewise, a physician who wrote a report for the Respondent on the Respondent's prescribing practices was accepted as an expert in pain management. Based upon the records admitted into evidence during the hearing, the attorneys for the State and for the Respondent each argued the issues in this matter.

On November 18, 2020, the ALJ issued a Proposed Decision. The ALJ proposed that all the grounds for discipline charged against the Respondent be upheld and that the Respondent's license to practice medicine be revoked.

The Respondent filed written exceptions with the Board. In the Respondent's exceptions, the numbering of disciplinary grounds appears mistaken at certain points, but it appears that he did not take exception to any of the ALJ's fact finding concerning violations of Health Occ. § 14-404(a)(2), (3), (11), and (36), and, in fact, does not appear to have taken any exceptions concerning the ALJ's proposed conclusions that the Respondent violated Health Occ. § 14-404(a)(2), (3), (11), and (36). The Panel believes that the Respondent did intend to take exception to certain findings the ALJ made in support of the findings that the Respondent violated Health Occ. § 14-404(a)(4), (17), and (27),[1] although the Respondent did not make any argument to support his purported exception concerning Health Occ. § 14-404(a)(17). On February 10, 2021, an oral exceptions hearing was held before Board Disciplinary Panel A (the "Panel" or "Panel A").

[1] On the second page of the Respondent's exceptions, the Respondent states that he "excepts to the finding[s] supporting violations of (4)(17) and *(36)*." (Italics added.) Based upon the remainder of the Respondent's exceptions, however, Panel A finds that he intended to state that he was taking exception to § 14-404(a)(4), (17), and (27).

FINDINGS OF FACT

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

1. At all times relevant to this proceeding, the Respondent was a licensed physician in Maryland. He maintained a solo medical practice known as Sunrise Medical Clinic, LLC, which he purchased in 2009. In 2009, Sunrise Medical Clinic was in Greenbelt, Maryland, and relocated to Lanham, Maryland in approximately the fall of 2017. Greenbelt and Lanham, Maryland, are in Prince George's County, Maryland, northeast of Washington, D.C., near the I-495 interstate beltway.

Prior Disciplinary History

2. On November 3, 2014, the Board issued charges against the Respondent that he had dispensed drugs without a license or permit authorizing him to do so; dispensed drugs without a label; dispensed drugs to individuals who were not his patients; and kept prescription medications, including samples, in an unlocked cabinet in a reception area which was accessible to staff and patients. The Board charges also included the Respondent's failure to maintain adequate medical records, including documenting patient histories, complaints of current illnesses, and efforts to reduce reliance on pain-killing medications, for patients to whom he prescribed pain-killing medications.

3. On March 12, 2015, the Respondent and the Board entered into a Consent Order. The Respondent's medical practice areas at the time consisted of internal medicine, pain management, and weight loss. The Consent Order included a provision that the Board was issuing a Reprimand to the Respondent, and that the Respondent would, among other things: be placed on probation for two years; discontinue prescribing opioid pain-killing medications until probation

was completed, except for emergencies; attend a pain management course; and attend a medical record-keeping course.

4. On September 17, 2015, the Board concluded that the Respondent had complied with the pain-management education portion of the March 12, 2015 Consent Order and restored the Respondent's authority to practice pain management and prescribe CDS.

5. On April 30, 2018, the Board issued charges against the Respondent for unprofessional conduct in the practice of medicine, willfully making false reports, failing to meet the appropriate standards in the delivery of medical care, making false representations on applications for licensure, and failing to keep adequate medical records.

6. On January 29, 2019, and ALJ conducted a hearing. On April 22, 2019, the ALJ issued a Proposed Decision in which the ALJ issued Proposed Findings of Fact, Proposed Conclusions of Law, and a Proposed Order. The ALJ proposed that the Board find that the Respondent: engaged in unprofessional conduct in the practice of medicine, failed to meet the appropriate standards of care, failed to comply with applicable provisions of the Pharmacy Act; failed to keep adequate medical records; failed to comply with Pharmacy Act provisions related to dispensing, maintaining, labeling and keeping records of dispensing CDS; failed to properly package prescription drugs (based on a finding of fact that the Respondent dispensed drugs in white envelopes and not in properly labeled child-resistant cap containers); and failed to provide adequate physical security and controls for CDS. The ALJ proposed that the Respondent's license be suspended for six months, that he be permanently prohibited from dispensing CDS from his office, and that the Respondent undergo an evaluation to determine whether he could safely return to the practice of medicine.

7. On September 30, 2019, the Respondent's license to practice medicine in Maryland expired.[2] Due to the pending action on the April 30, 2018 charges, his license was extended until the action by the Board on the charges.

8. On November 5, 2019, Disciplinary Panel A of the Board adopted the ALJ's proposed Findings of Fact and Conclusions of Law and ordered that the Respondent's license be suspended for a minimum of six months and ordered that he undergo an evaluation on whether he could safely return to the practice of medicine.

Current Proceeding

9. On January 4, 2019, the Board received a complaint from the Maryland Department of Health ("MDH") Office of the Inspector General ("OIG") that the Respondent was prescribing large amounts of high-dose opioids, which are controlled dangerous substances ("CDS"), to customers who were paying cash, many of whom had criminal histories involving CDS or who were currently or previously enrolled in opioid dependence treatment programs. The OIG also complained that many of the persons for whom the Respondent prescribed opioids were receiving 90 morphine milligram equivalents or more per day, which exceeded CDC guidelines, and that many of the persons for whom the Respondent prescribed opioids lived at the same residential address or were linked to common social media groups (i.e. they were Facebook friends). Based upon the complaint, the Board immediately began an investigation into the Respondent's practice.

10. In the period June 21, 2017 through January 31, 2019, the Respondent issued over 7,300 prescriptions for CDS. In the months of November 2018 through January 2019, 190 of those prescriptions were for opioids.

---

[2] Under § 14-403 of the Health Occupations Article, the license of an individual regulated by the Board may not "lapse by operation of law while the individual is under investigation or while charges are pending."

11. For 20 patients, for the period June 21, 2017 through January 31, 2019, the Respondent repeatedly issued prescriptions for high-dose CDS. The Respondent's medical records do not reveal why high-dose CDS were prescribed or why, for several patients, more than one high-dose CDS was prescribed for the same patient at a single office visit.

12. The Respondent inadequately monitored the 20 patients for their use of CDS by failing to conduct a sufficient number of laboratory testing for CDS levels. The Respondent also failed to compose any plans for tapering the use of CDS, for decreasing dependence on CDS, for weaning off CDS altogether, or for working with the Respondent to develop therapies other than continued use of CDS. On rare occasions when urine tests were conducted, the results of the tests often revealed no CDS in fluids of patients to whom CDS were prescribed, indicating that the patients were not taking the CDS that the Respondent prescribed.

13. Numerous urine tests revealed efforts by patients to mask the use of CDS, such as using cocaine or methadone prior to a urine test. The Respondent's patient records reveal no mention of any effort by the Respondent to address concerns that the patients may be masking their CDS use, or efforts to determine why, if CDS were prescribed, they were not revealed in urine tests.

14. The Respondent's records reveal no effort by the Respondent to determine if the patients who were prescribed CDS were also receiving CDS prescriptions from other prescribers.

15. The Respondent issued prescriptions for opioids to patients to whom he had also prescribed sedatives, muscle relaxers, and benzodiazepines. Sedatives, muscle relaxers, and benzodiazepines, taken in combination with opioids, increases the risk of adverse consequences.

16. The Respondent did not prescribe emergency opioid reversal medication, such as Narcan, to patients to whom he issued prescriptions for opioids.

17. For almost every patient at issue, the Respondent prescribed high dose opioids without attempting, or real consideration of, lower doses to see whether the lower doses were effective in treating the patients. Instead, generally, the Respondent immediately and repeatedly prescribed opioids in doses that exceeded CDC guidelines.

18. The Respondent repeatedly prescribed CDS to patients who were currently enrolled in CDS treatment programs and who were concurrently taking methadone.

19. Several of the Respondent's patients had positive laboratory tests for drugs the Respondent had not prescribed, such as fentanyl, and who had no evidence of the presence of drugs the Respondent had prescribed, such as Xanax.

20. On February 7, 2019, the Board issued a subpoena to the Respondent for medical records of 20 patients, which the Respondent delivered. Of the 20 patients whose records the Board subpoenaed, 16 had histories of prosecution for possession or possession and distribution of CDS.

21. Patient 5,[3] who lives in Baltimore City, has a history of prosecutions for possession of CDS from 2001 through 2006.

22. Patient 6, who lived in Catonsville, Baltimore City, Curtis Bay and Halethorpe, Maryland, has a history of prosecutions for possession of CDS from 2007 through 2014.

23. Patient 12, who lives in Centreville, Maryland, has a history of prosecution for possession of CDS in 2018.

24. Patient 15, who lives in Prince Frederick, Maryland, has a history of prosecutions for possession of CDS from 2015 through 2019.

[3] The Panel refers to the patients by the number they are listed under in the Board's February 7, 2019, subpoena to the Respondent.

25. Patient 13, who lives in Suitland, Maryland, has a history of prosecutions for possession of CDS in 2003.

26. Patient 8, who lives in Prince Frederick, Maryland, has a history of prosecutions for possession of CDS from 2008 through 2017.

27. Patient 10, who lives in LaPlata, Maryland, has a history of prosecutions for possession of, and for distribution of, CDS from 1991 through 2018.

28. Patient 1, who lives in Prince Frederick, Maryland, has a history of prosecution for possession of CDS in 2013.

29. Patient 16, who lives in Lexington Park, Maryland, has a history of prosecutions for possession of CDS from 2003 through 2018.

30. Patient 4, who lives in Dundalk, Maryland, has a history of prosecution for possession of CDS in 2013.

31. Patient 3, who lives in Crownsville, Maryland, has a history of prosecution for possession of CDS in 2013.

32. Patient 17, who lives in Rosedale, Maryland, has a history of prosecutions for possession of CDS from 1998 through 2014.

33. Patient 20, who lives in Chesapeake Beach, Maryland, has a history of prosecution for possession of CDS in 1998.

34. Patient 18, who lives in Glen Burnie, Maryland, has a history of prosecution for possession of CDS in 2017.

35. Patient 11, who lives in Glen Burnie, Maryland, at the same address as Patient 18, has a history of prosecutions for possession of CDS from 2002 through 2016.

36. Patient 7, who lives in Baltimore, Maryland, has a history of prosecutions for possession of CDS from 2010 through 2012.

37. Many of the patients had insurance that could have covered their medical treatment but decided to pay cash to obtain prescriptions from the Respondent instead of using their insurance, perhaps elsewhere, for the treatment they purportedly sought.

38. During the relevant time frame, the Respondent displayed placards on his office walls that he was currently board-certified in internal medicine, and the Respondent's prescription pads also stated that he was board-certified in internal medicine. Likewise, the Respondent's letterhead represented that he was board-certified in internal medicine. Further, the Respondent represented on his 2013, 2015, and 2017, license renewal applications he filed with the Board to practice medicine that he was board-certified in internal medicine. Since 2011, the Respondent was not board-certified in internal medicine.

DISCUSSION

At the OAH proceeding, in this case, the Respondent and the State entered into Joint Stipulations of Facts and Evidence Not in Dispute, which states:

> Stipulation #1: The *Charges Under the Maryland Medical Practice Act,* issued July 23, 2019, are not contested, with the following three exceptions: The Respondent contests and does NOT agree that he violated three of the cited charges: 1. Health Occ. § 14-404(a)(4) ("Is professionally, physically, or mentally incompetent"); 2. Health Occ. § 14-404(a)(17) ("Makes a willful misrepresentation in treatment"); 3. Health Occ. § 14-404(a)(27) ("Sells, prescribes, gives away, or administers for illegal or illegitimate medical purposes"). Stipulation #2: Joint Exhibits 1 through 70 are not contested. Stipulation #3: The Parties differ as to the appropriate sanction.

The ALJ issued Proposed Conclusions of Law that the Respondent violated all of the disciplinary grounds charged, which are:

1. Health Occ. § 14-404(a)(2) (Fraudulently or deceptively using a license);

2. Health Occ. § 14-404(a)(3) (Is guilty of: (i) Immoral conduct in the practice of medicine; or (ii) Unprofessional conduct in the practice of medicine);

3. Health Occ. § 14-404(a)(4) (Is professionally, physically, or mentally incompetent);

4. Health Occ. § 14-404(a)(11) (Willfully makes or files a false report in the practice of medicine);

5. Health Occ. § 14-404(a)(17) (Makes a willful misrepresentation in treatment);

6. Health Occ. § 14-404(a)(27) (Sells, prescribes, gives away, or administers drugs for illegal or illegitimate medical purposes); and

7. Health Occ. 14-404(a)(36) (Willfully makes a false representation when seeking or making application for licensure or any other application for related to the practice of medicine).

The Respondent filed Exceptions, but he did not take exception to the ALJ's Proposed Conclusions of Law that he violated Health Occ. § 14-404(a)(2), (3), (11), and (36). The Respondent, however, seems to have intended to take exception to the ALJ's Proposed Conclusions of Law that he violated Health Occ. § 14-404(a)(4), (17), and (27).

The Respondent did not contest the Health Occ. § 14-404(a)(2), (3), (11), or (36) charges during the OAH proceeding, nor did he file exceptions to the ALJ's conclusions that he violated these charges.[4] These grounds are based upon the Respondent's intentionally false statements on

---

[4] The Respondent was also charged with violating Health Occ. § 14-404(a)(3) for "excessive and irresponsible prescribing practices." (Charges at page 8). It does not appear the Respondent has contested this Health Occ. § 14-404(a)(3) charge related to his prescribing practices. Based upon the State's expert's review of the relevant documents, the State's expert's opinion, concerning the Respondent's prescribing, is that the Respondent is guilty of unprofessional conduct in the practice of medicine. The Panel accepts this opinion and finds that the evidence related to his egregious prescribing practices, discussed and described in this decision, proves a violation of Health Occ. § 14-404(a)(3).

his 2013, 2015, and 2017 Board license renewal applications, on his prescription pads, on placards on his office walls, and on his letterhead that he was board-certified in internal medicine. The Respondent's board-certification in internal medicine expired in 2011. Panel A adopts the ALJ's proposed conclusions of law that the Respondent violated Health Occ. § 14-404(a)(2), (3), (11), and (36), for these deliberate misrepresentations.

Health Occ. § 14-404(a)(4) (Is professionally, physically, or mentally incompetent)

Concerning Health Occ. § 14-404(a)(4), the ALJ found overwhelming evidence of professional incompetence. The ALJ relied upon *Blaker v. Board of Chiropractic Examiners,* 123 Md. App. 243, 258 (1998), which states, "[i]n common parlance, 'incompetence' means a lack of the learning or skill necessary to perform, day in and day out, the characteristic tasks of a given calling in at least a reasonably effective way. Competency does not mean perfection...." The ALJ found that under this standard, the Respondent was incompetent and was not able to perform the "characteristic tasks of a doctor in anything close to a reasonably effective way." The Panel finds that this description fits the Respondent in this matter.

The Respondent's prescribing of high doses of potent CDS without supported medical reasoning for the dosages prescribed and without adequate compliance monitoring was systemic. When toxicology screening was performed, the results regularly showed that the patients were non-compliant with the medication regimen instituted by the Respondent, used illicit substances, tampered with the urine samples they provided for testing, and several patients who were prescribed opioids by the Respondent were also prescribed methadone by an opioid addiction treatment program. The results from the limited toxicology screening, however, did not guide the Respondent's decision-making with respect to the clinical course of the patients. The non-

compliance was not addressed by modifying the treatment plans, decreasing dosages, discontinuing medications, or discharging the patients from his practice.

Further, as the ALJ correctly specified, the CDS prescriptions were made mostly with no evaluation, no treatment plan, no attempts at low-dose prescription to test therapeutic effectiveness before increasing the dose to greater that CDC guidelines, and no prescription for Narcan or another drug to counteract an overdose. The Panel accepts these findings by the ALJ.

It appears the Respondent took exception to the ALJ's conclusion of a violation of Health Occ. § 14-404(a)(4) by contesting the ALJ's proposed finding of fact 18, which states, "The Respondent issued prescriptions for opioids to patients to whom he had also prescribed sedatives, muscle relaxers and benzodiazepines. Sedatives, muscle relaxers and benzodiazepines, taken in combination with opioids, increases the risk of adverse consequences from use of the opioids." The Respondent argues, "Benzodiazepines are obviously indicated in patients with anxiety in combination with chronic pain." The Respondent asserts that he "prescribed low dose of Benzodiazepines while informing patients about the risks associated with opioid side effects." The Respondent's exception does not cite to the record showing the instances in which he prescribed low doses of benzodiazepines for anxiety patients also taking opioids and where the patients were also informed of the risks. However, because of the overwhelming evidence supporting the conclusion that the Respondent is professionally incompetent, even without his prescribing opioids concurrently with benzodiazepines, the Panel, in its discretion, is not basing its finding of a violation of Health Occ. § 14-404(a)(4) upon these concurrent prescriptions.

The Respondent also took exception to the ALJ's proposed finding of fact 20, which states, "There is no record the Respondent issued prescription for low-dose CDS to any patient to determine a therapeutic level for the medicine. Instead, the Respondent immediately and

repeatedly prescribed opioids in doses that exceeded CDC guidelines." The Respondent states that the ALJ erred because, according to the Respondent, "some of the patients came to the Respondent's Clinic while taking 30mg of Oxycodone which was reduced to 15mg or less in keeping with the CDC Guidelines clarification." In support, the Respondent cites, in general, to one patient chart. In any case, the Panel will modify the finding to state, "For almost every patient at issue, the Respondent prescribed high dose opioids without attempting, or real consideration of, lower doses to determine whether the lower doses were effective in treating the patients. Instead, generally, the Respondent immediately and repeatedly prescribed opioids in doses that exceeded CDC guidelines." (Finding of Fact 17 in this decision).

For the reasons set forth above, it is without question that the Respondent is professionally incompetent, in violation of Health Occ. § 14-404(a)(4).

Health Occ. § 14-404(a)(27) (Sells, prescribes, gives away, or administers drugs for illegal or illegitimate medical purposes)

The ALJ found overwhelming evidence showing that the Respondent prescribed CDS for illegal or illegitimate medical purposes, in violation of Health Occ. § 14-404(a)(27). Panel A, likewise, has found the same. From June 2017 through January 2019, the Respondent issued thousands of prescriptions for CDS. These prescriptions were issued to individuals with criminal histories of prosecution for possession and distribution of CDS. These individuals travelled from all over the State, including the Eastern Shore, southern Maryland, and central Maryland to his office for these prescriptions. Most of these individuals did not live near his office. On the rare occasions when there were results from toxicology screening, there were often results indicating that patients were non-complaint with the medication regimens prescribed by the Respondent. Nonetheless, the Respondent did not modify his treatment of the patients or seem to take these aberrant results into account in his treatment. His records do not indicate that he addressed or even

considered the serious indicators that his patients were tampering with the urine samples. The Respondent prescribed high doses of opioids with high potential for adverse reactions and diversion, without taking these crucial concerns into account. Most of the prescriptions were also not supported with medical reasoning, documentation, or evaluation. Without question, the Respondent prescribed CDS for illegitimate medical purposes.

The Respondent took exception to paragraph 15 of the ALJ's proposed Findings of Fact, which states, in pertinent part, "The Respondent did not monitor any of the twenty patients for their use of CDS by conducting laboratory testing for CDS . . . On rare occasions when urine tests were done, test results revealed no CDS in the fluid of patients to whom CDS were prescribed." The Respondent states that he "did laboratory tests to monitor CDS . . . and the dates and results of these tests are confirmed in the patients' medical records." The Respondent simply cites in general to all the medical records, providing no indication that the testing was not, as the ALJ found, "[o]n rare occasions." While drug testing was performed on rare occasions, the number of occasions was wholly insufficient for effectively monitoring his patients. The Panel, however, does feel, as does the Respondent, that "no monitoring" may have been imprecise. The Panel therefore revises the finding to state that the monitoring was inadequate. (Finding of Fact 12 in this decision.) The Respondent did order toxicology screening, which is part of monitoring, but the Respondent required the screening on an inadequate number of occasions and essentially disregarded the results.

The Respondent also took exception to the ALJ's proposed Finding of Fact 40, which states, "Many of the patients for whom the Respondent prescribed CDS had insurance that would have covered the cost of the clinic visit, but the Respondent accepted cash payment rather than accepting insurance coverage payment." The Respondent contends that the Respondent explained

the cash payments in a letter he sent the Board, dated February 14, 2019 (Exhibit 21), which states, "There are no separate Billing Records other than what have been produced for the twenty (20) patients. Those patients either did not have Health Insurances that my Clinic could bill or my Clinic did not participate in the Insurances they had. They made payments as services were rendered to them." The Panel finds that the ALJ's proposed finding indicates that the patients had insurance that could have covered the relevant treatment but decided to pay cash to obtain prescriptions from the Respondent instead of using their insurance elsewhere to cover the cost of the visit. The Panel has modified the finding to make the point clear. (Finding of Fact 37 in this decision.) The significance is that the patients would rather pay cash to the Respondent to avoid any questions or inquires as to the legitimacy of the visits from those that insured them or accepted their insurance.

The State's expert reviewed the 20 patient records for the Board and found:

> My review of these patient records demonstrates a pervasive theme of prescribing high potency opioid medications without supporting medical reasoning, without proper compliance monitoring, and blatantly ignoring compliance issues, thus putting these patients at risk for overdose. This behavior in combination with accepting cash payments for medical services from patients with established medical assistance insurance supports that Dr. Ojiegbe is aware that patients are trying to obtain prescription opioid medications for illicit use, abuse, or diversion.

The Panel readily agrees with and accepts this assessment of the Respondent's prescribing practices. In the opinion of the State's expert, the Respondent's prescriptions were "for illegal or illegitimate medical purposes." The Panel agrees with this opinion.

The State's expert specified in his report serious and obvious concerns regarding eight of the patient charts he reviewed which highlighted that the patients were clearly non-compliant with treatment, yet the Respondent continued to prescribe them high potency CDS. For instance, the State's expert wrote:

> Patient 6 had two positive urine toxicology tests for both oxycodone and methadone on 7/28/17 and 3/17/2018. With two documented non-compliant urine tests, and with being enrolled in a methadone maintenance program, Patient 6 should have never been prescribed opioids. Patient 6 who lived at the same address as Patient 5, who also tested positive for methadone and oxycodone on 8/5/2017 and 6/7/2018. In both patient charts there was no mention of the non-compliant drug testing, counseling, or follow up screening.
>
> Patient 12 tested positive for cocaine 10/26/2017 . . . ., in addition to oxycodone with no metabolite, suggesting that the patient simply sprinkled some oxycodone into the urine sample to try to get a false positive result. No changes were made in the treatment regimen and the patient tested non-compliant on 3/26/2018 when both oxycodone and alprazolam (Xanax) without the appropriate metabolites were detected.
>
> . . . .
>
> Patient 13 tested non-compliant on 7/29/2017 and 2/27/2017, and then non-compliant for Xanax metabolite, as well as fentanyl positive on 2/6/18.

The State's expert detailed four other instances demonstrating a pattern of the Respondent ignoring clear indications of non-compliance and likely diversion of CDS. The Respondent relies upon his own pain management expert's report, stating that his expert reviewed seven of the patient records and the State's expert report and "opined that there were no medical grounds to support the State's Expert opinion that the Respondent was prescribing opioids for illegal or illegitimate medical purposes." The Respondent's expert, however, did not address the central focus of State's expert report, which was that, when the Respondent did laboratory testing for compliance with his medication regimen, the Respondent did not address his patients' noncompliance. Nor did the Respondent's expert address the indicators of diversion that the State's expert described. Disregarding the focusses of the State's expert report diminished the weight of the Respondent's expert's opinions. The Panel finds the State's expert's report well-supported and more persuasive than the Respondent's expert's report. The Panel thus relied extensively on the State's expert.

The Respondent further relies upon an unidentified article, purportedly published in 1983, in which the unnamed "DEA Associate Chief Counsel" allegedly said (without quotation), "Acts of prescribing or dispensing of controlled substances which are done within the course of the registrant's professional practice are, for purposes of the Controlled Substance Act, lawful." The Respondent then goes on to offer, "It matters not that such act might constitute terrible medicine or malpractice. They may reflect the grossest form of medical misconduct or negligence. They are nevertheless legal." The Panel does not accept that this statement absolves the Respondent. The Respondent was not charged under the Controlled Substances Act, he was charged under the Maryland Medical Practice Act, and the alleged statement of an unnamed DEA counsel, published in an unnamed article in 1983, does not convince the Panel that the Respondent did not violate the Maryland Medical Practice Act. In any event, the Maryland Medical Practice Act is intended to sanction "the grossest form[s] of medical misconduct."

The Respondent also states, "the Respondent could not possibly be prescribing for illegal or illegitimate medical purposes because the [2019] CDC Response . . . made clear to health professionals that the CDC's 2016 Guideline offered no support for mandatory opioid dose reductions in patients with long-term care." The Respondent, however, does not cite to where the ALJ allegedly found that opioid dose reduction in patients with long-term pain was "mandatory." The Respondent further asserts, again without citation, that "cautionary dose thresholds from the CDC's 2016 Guideline have been intended to apply *only* for initiation of opioids, rather than for the care of longstanding recipients who were stable at higher doses." But the cover letter, dated April 10, 2019, to the Clarification of the 2016 CDC Guideline (Exhibit 68) seems to say something different: the "recommendation on high-dose prescribing focuses on initiation. The Guideline offers different recommendations for patients already on dosages greater than or equal

to 90 morphine milligram equivalents per day." In any case, the Respondent does not address how the 2019 CDC Clarification pertains to the Respondent's failures with respect to his patients' noncompliance and indicators of diversion.

For the reasons explained above, the Respondent violated Health Occ. § 14-404(a)(27).

Health Occ. § 14-404(a)(17) (Makes a willful misrepresentation in treatment)

The ALJ found that the Respondent violated Health Occ. § 14-404(a)(17). The Respondent stated in his written exceptions that he excepts to that finding, however, the Respondent set forth no argument or reason explaining why he did not violate Health Occ. § 14-404(a)(17). In multiple manners described above, the Respondent intentionally represented falsely that he was board-certified in internal medicine, when he has not been board-certified in internal medicine since 2011. For instance, his prescription pads falsely stated that he was board-certified in internal medicine. The Respondent, thus, made a willful misrepresentation in treatment, in violation of Health Occ. § 14-404(a)(17).

CONCLUSIONS OF LAW

Based upon the Findings of Fact and Discussion, Panel A concludes that the Respondent: Fraudulently or deceptively used a license, in violation of Health Occ. § 14-404(a)(2); Is guilty of: (i) Immoral conduct in the practice of medicine, or (ii) unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3); Is professionally, physically, or mentally incompetent, in violation of Health Occ. § 14-404(a)(4); Willfully made or filed a false report or record in the practice of medicine, in violation of Health Occ. § 14-404(a)(11); Made a willful misrepresentation in treatment, in violation of Health Occ. § 14-404(a)(17); Sold, prescribed, gave away, or administered drugs for illegal or illegitimate medical purposes, in violation of Health Occ. § 14-404(a)(27); and Willfully made a false representation when seeking or making

application for licensure or any other application related to the practice of medicine, in violation of Health Occ. § 14-404(a)(36).

SANCTION

The ALJ recommended the revocation of the Respondent's license, noting, "[n]o mitigating factors are present," and "[a]ll the aggravating factors are present." Most significantly, the ALJ found the "Respondent's prescription methods had no relationship whatsoever to patient welfare." The ALJ also mentioned that each of the seven disciplinary grounds violated, standing alone, subjects the Respondent to the possible sanction of revocation. And "[c]ollectively the violations, in conjunction with the Respondent's history of sanctions and failure of rehabilitation, warrant revocation of the Respondent's license."

The Respondent took exception to the ALJ's recommended sanction. Essentially, the Respondent argues that the Panel should prohibit him from prescribing CDS (which he states has already occurred through his surrender of his DEA registration) and impose a period of suspension. He says that his "acceptance of errors and surrender of his CDS license" constitute a mitigating factor and that he should concentrate on internal medicine. He also claims that "the CDC Response of April 10, 2019 clarifying the CDC guidelines mitigates any perceived conduct by Dr. Ojiegbe in CDS prescriptions" for the 20 patients at issue in this case.

It is apparent to Panel A that the Respondent was more than willing to prescribe high potency CDS to individuals exhibiting the blatant signals that the prescriptions were for abuse or diversion. The Panel cannot fathom how his conduct was not deliberate. Moreover, the Respondent has shown little to no acknowledgment as to the nature of his egregious conduct and, thus, the Panel cannot allow the Respondent to continue to abuse a medical license and jeopardize the health and safety of his patients and the public.

In considering aggravating factors, COMAR 10.32.02.09B(6), the most significant are that the Respondent has a disciplinary history with the Board, the conduct was committed deliberately, the offenses had the potential for patient harm, and there was a pattern to his conduct. The Panel does not find any significant mitigating factors. COMAR 10.32.02.09B(5). When the Respondent's conduct is considered with the extensive and significant violations in this case and his disciplinary history, permanent revocation of the Respondent's license is warranted.

ORDER

It is, on the affirmative vote of a majority of the quorum of Board Disciplinary Panel A, hereby

ORDERED that the license of Vitalis O. Ojiegbe, M.D. (License No. D65418) to practice medicine in Maryland is **PERMANENTLY REVOKED;** and it is further

ORDERED that this Final Decision and Order is effective and filed upon the signature of the Board's Executive Director, who signs on behalf of Board Disciplinary Panel A.

ORDERED that this is a public document. *See* Health Occ. § 1-607; Health Occ. § 14-411.1; Md. Code Ann., Gen. Prov. § 4-333(b)(6).

Signature on File

05/14/2021
Date

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

NOTICE OF RIGHT TO APPEAL

Pursuant to § 14-408(a) of the Health Occupations Article, the Respondent has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review must be filed within 30 days from the date this Final Decision and Order was sent to the Respondent. The Final Decision and Order was sent on the date of the cover letter accompanying the Final Decision

and Order. The petition for judicial review must be made as directed in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222, and Maryland Rules 7-201 *et seq.*

If the Respondent petitions for judicial review of this Final Decision and Order, the Board is a party and should be served with the court's process. In addition, the Respondent should send a copy of the petition for judicial review to the Board's counsel, David Wagner, Assistant Attorney General, Office of the Attorney General, 300 W. Preston Street, Suite 302, Baltimore, Maryland 21201. The administrative prosecutor is not involved in the circuit court process and does not need to be served or copied on pleadings filed in circuit court.