IN THE MATTER OF	*	**BEFORE THE**
AMINULLAH AMINI, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D67880	*	**Case Number: 2219-0212B**

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CONSENT ORDER

On February 10, 2021, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") charged Aminullah Amini, M.D. ("the Respondent") under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. §§ 14-101—14-702 (2014 Repl. Vol. & 2019 Supp.).

Specifically, the Respondent was charged with violating the following:

Health Occ. § 14-404.

(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[.]

One form of unprofessional conduct in the practice of medicine is "disruptive behavior." "Disruptive physician behavior" has been addressed by The Joint Commission and the American Medical Association ("AMA").

JOINT COMMISSION SENTINEL EVENT ALERT, 2008

On July 9, 2008, The Joint Commission issued a Sentinel Event alert entitled "Behaviors that Undermine a Culture of Safety," which stated in pertinent part:

> Intimidating and disruptive behaviors can foster medical errors . . . contribute to poor patient satisfaction and to preventable adverse outcomes . . . increase the cost of care . . . and cause qualified clinicians, administrators and managers to seek new positions in more professional environments . . . Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.
>
> Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions . . . Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients . . . All intimidating and disruptive behaviors are unprofessional and should not be tolerated.[1,2]

AMA OPINION 9.045, JUNE 2000

AMA Opinion 9.045, entitled, *Physicians with Disruptive Behavior*, adopted in June 2000, states in pertinent part:

> . . .
>
> (1) Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.) However, criticism that is offered in good faith with the

[1] In 2011, The Joint Commission revised the term "disruptive behavior" to "behavior or behaviors that undermine a culture of safety."

[2] In 2016, The Joint Commission noted that "while the term 'unprofessional behavior' is preferred instead of 'disruptive behavior;' the suggested actions in this alert remain relevant."

aim of improving patient care should not be construed as disruptive behavior.

AMA OPINION 9.4.4, JUNE 2016

AMA Code of Medical Ethics: Professional Self-Regulation Opinion 9.4.4, adopted in June 2016, pertaining to Physicians with Disruptive Behavior, states in pertinent part:

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

On May 26, 2021, Panel B 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

Panel B finds the following facts:

I. BACKGROUND

1. At all times relevant, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on June 24, 2008, under License Number: D67880, and his license is currently scheduled for renewal on September 30, 2022.

2. The Respondent is board certified in Neurosurgery and, all times relevant, was employed in the private practice of medicine in Montgomery County, Maryland.

II. THE COMPLAINT

3. On or about May 13, 2019, the Board received a complaint from a physician (the "Complainant")[3] alleging that the Respondent exhibited a pattern of escalating unprofessional behavior consistent with being unreasonable, threatening, and retaliatory. The complaint alleged that the Respondent engaged in unprofessional behaviors towards physician assistants and surgical staff and engaged in threatening behavior towards the complainant which made her fear retaliation from the Respondent.

4. After receiving the complaint, the Board initiated an investigation of the Respondent.

III. BOARD INVESTIGATION

5. On or about November 27, 2019, Board staff notified the Respondent that the Board received a complaint alleging unprofessional conduct, informed the Respondent that an investigation was initiated, and requested a written response to the allegations.

6. In furtherance of the Board's investigation, Board staff conducted interviews of witnesses, as well as subpoenaed the Quality Assurance and Risk Management ("QA/RM") files from health care facilities where the Respondent worked.

Facility A

7. On or about July 30, 2019, Board staff conducted an interview of the Complainant. During the interview, the Complainant stated that in 2013 she began taking call with the Respondent at a health care facility ("Facility A") located in Prince George's County,

[3] In order to maintain confidentiality, the names of witnesses and facilities will not be used in this document.

Maryland. She described her working relationship with the Respondent as a "healthy professional relationship" until she became Chief of Surgery at Facility A in February 2019. The Complainant described the Respondent's behavior towards subordinate staff as "aggressive, disruptive and argumentative." She had concerns about the Respondent's behavior towards a physician assistant ("Physician Assistant 1") and stated that on several occasions, the Respondent was overheard yelling and screaming at Physician Assistant 1. The Complainant stated that the Respondent's behavior was vindictive and irrational.

8. The Complainant and the Respondent also had a disagreement regarding the on-call schedule during 2019, which led to a meeting between the two of them. During the meeting, the Respondent became very upset and asked to record their conversation. After the meeting, the Respondent informed the Complainant that he would no longer provide on call coverage for her. As a result of this encounter, the Complainant said she was fearful of retaliation by the Respondent and reported her concerns to security at Facility A.

9. On or about November 6, 2019, Board staff conducted an interview of Physician Assistant 1. During the interview, Physician Assistant 1 stated that she worked at Facility A on the neurosurgery service in 2016 and the Respondent was her supervisor. Physician Assistant 1 said that it was "difficult" to work for the Respondent. She described the Respondent as short-tempered, verbally aggressive, and that she was "afraid of him." According to Physician Assistant 1, on one occasion the Respondent reprimanded her in a conference room by cursing at her and telling her that she was a bad physician assistant, which made her cry. After the incident, Physician Assistant 1 requested to be transferred off of the neurosurgery service but was required to stay on due to staff shortage. Physician

Assistant 1 stated that the Respondent's behavior towards her affected her ability to perform her job "because [she] would be so messed up. . . literally shaking so [she] couldn't function."

10. On or about September 24, 2020, Board staff conducted an interview of a surgical technician (the "Surgical Technician"), who worked with the Respondent at Facility A. During the interview, the Surgical Technician stated that on November 13, 2018, the Respondent was working at Facility A performing a craniotomy. While in the operating room, the Respondent was working with the Surgical Technician and a registered nurse. During the procedure, the Respondent became rude and started making derogatory comments to the Surgical Technician. The Respondent then began to raise his voice and exhibited intimidating behavior toward the Surgical Technician's head to the extent that the Surgical Technician requested for relief. When the Surgical Technician asked to be relieved, the Respondent escalated the matter by screaming "get out" repeatedly at the top of his voice. The Respondent then removed his surgical gown and gloves and discontinued the procedure.

11. The Respondent began to depart from the operating room when the Surgical Technician notified him that she would leave the room upon being relieved. A short time later, the Respondent returned to the operating room without his gloves or surgical gown and told Surgical Technician "you are still in here, get her out of here." The Respondent

then placed his hands on the upper body of the Surgical Technician and said, "you are now contaminated, so you can get out."

12. Following the incident, Facility A conducted an inquiry of the incident. When asked regarding his physical contact with the Surgical Technician, the Respondent admitted "out of exasperation and a need to get back to my patient who was still on the table, I touched her elbow lightly and told her she was no longer sterile and had to leave." Based on the inquiry, Facility A counseled the Respondent as a result of his conduct towards the Surgical Technician.

Facility B

13. On or about July 8, 2020, Board staff interviewed a physician assistant ("Physician Assistant 2") who worked with the Respondent from July 2016 to January 2019 at a health care facility ("Facility B") located in Montgomery County, Maryland. During the interview, Physician Assistant 2 stated that she worked at Facility B on the neurosurgery service and the Respondent was her supervising physician. Physician Assistant 2 described her interactions with the Respondent as very tense. Physician Assistant 2 stated that while the Respondent is professional regarding his treatments of patients, he was not very approachable. Physician Assistant 2 stated that she was always nervous because she was afraid that the Respondent would get angry. Physician Assistant 2 further stated that the Respondent would yell at other hospital staff noting that they were incompetent and did not deserve to work there.

14. Physician Assistant 2 stated that in November 2018, she left the neurosurgery service following an incident with the Respondent. Physician Assistant 2 stated that on that

occasion, she called the Respondent, who was in a procedure, about a newly admitted patient about whom she was concerned. Physician Assistant 2 stated that the Respondent at first was silent, and then started screaming at her for at least five minutes. Physician Assistant 2 stated that everyone around her could hear the Respondent screaming at her as she was talking to the Respondent using a cell phone. Physician Assistant 2 stated that after the Respondent stopped screaming at her, she was so shaken and upset that she decided to quit the neurosurgery service as a result of the incident. Physician Assistant further noted that the Respondent never apologized to her for his behavior during the incident.

15. The Respondent's QA/RM file at Facility B further documented an incident in which he was counseled for exhibiting unprofessional and intimidating behavior toward a nurse in a different unit of Facility B. The Respondent attempted to access the medical record of a patient, who was at this separate unit of Facility B, stating that he was a friend of the patient's family. When the nurse refused to grant him access, he became unprofessional and intimidating towards her.

Facility C

16. From April 2018 to January 2020, the Respondent was involved in 8 events at a health care facility ("Facility C") located in Montgomery County, Maryland, regarding inconsiderate, rude, hostile, or inappropriate behavior.

17. In February 2020, the Respondent was counseled by leadership regarding his pattern of unprofessional behavior towards staff and it was recommended that the Respondent enroll in professional development courses to help with his behavior.

CONCLUSIONS OF LAW

Based on the Findings of Fact, Panel B 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, on the affirmative vote of a majority of the quorum of Board Disciplinary Panel B, hereby

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

ORDERED that within **SIX MONTHS**, the Respondent is required to take and successfully complete a course in workplace communication. The following terms apply:

(a) it is the Respondent's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the course before the course begins;

(b) the Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the course;

(c) the course may not be used to fulfill the continuing medical education credits required for license renewal; and

(d) the Respondent is responsible for the cost of the course; and it is further

ORDERED that within **ONE YEAR**, the Respondent shall pay a civil fine of **$25,000**. The Payment shall be by money order or bank certified check made payable to the Maryland Board of Physicians and mailed to P.O. Box 37217, Baltimore, Maryland 21297. The Board will not renew or reinstate the Respondent's license if the Respondent fails to timely pay the fine to the Board; and it is further

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

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

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

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

06/22/2021
Date

Signature on File

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

CONSENT

I, Aminullah Amini, M.D., acknowledge that I have consulted with legal 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 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

6/11/21
Date

Aminullah Amini, M.D.
Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Montgomery

I HEREBY CERTIFY that on this 11 day of June 2021, before me, a Notary Public of the foregoing State and City/County, appeared Aminullah Amini, M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

LUIS E. MARTINEZ
Notary Public – State of Maryland
Montgomery County
My Commission Expires Oct 2, 2021

Notary Public

My Commission expires: 10-02-2021