IN THE MATTER OF	*	**BEFORE THE**
MATTHEW MINTZ, M.D.	*	**MARYLAND STATE**
Respondent.	*	**BOARD OF PHYSICIANS**
License Number: D72166	*	**Case Number: 2221-0069B**

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

FINAL DECISION AND ORDER

On October 8, 2021, the Maryland State Board of Physicians ("Board") charged Matthew Mintz, M.D., a board-certified internal medicine physician, with failing to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care ("standard of care") performed in an outpatient surgical facility, office, hospital or any other location in this state and failing to keep adequate medical records as determined by appropriate peer review under Md. Code Ann., Health Occ. § 14-404(a)(22) and (40), respectively. The charges alleged that Dr. Mintz failed to meet the standard of care pertaining to his prescribing of opioids and that his medical recordkeeping was inadequate. On March 4, 2022, prior to a hearing at the Office of Administrative Hearings ("OAH"), Dr. Mintz and the State jointly filed Stipulations as to Findings of Fact and Conclusions of Law. On April 11, 2022, Dr. Mintz received an evidentiary hearing before an Administrative Law Judge ("ALJ") at OAH.

On July 5, 2022, the ALJ issued a proposed decision. The ALJ adopted the Stipulated Findings of Fact, made additional Proposed Findings of Fact, and adopted the stipulated Conclusions of Law, concluding that Dr. Mintz was guilty of a violation of the standard of care with respect to his opioid prescribing and that he failed to keep adequate medical records. The ALJ recommended: (1) a reprimand, (2) a permanent prohibition of prescribing and dispensing

opioids, (3) a permanent prohibition on his ability to certify patients for medical cannabis, (4) probation and a probationary condition to complete a Board-approved course in medical record-keeping, and (5) a $1,000 fine. Dr. Mintz filed exceptions as to the sanction only, objecting primarily to the proposed prohibition on certifying patients for cannabis, and accepting the Stipulated Findings of Fact, Proposed Findings of Fact, Stipulated Conclusions of Law, and the remainder of the recommended sanction. Disciplinary Panel A of the Board ("the Panel") heard arguments on Dr. Mintz's exceptions on October 12, 2022.

FINDINGS OF FACT

The Panel adopts the ALJ's Stipulations of Fact ¶¶ 1-15 and Proposed Findings of Fact ¶¶1-7. The ALJ's adopted Stipulations of Fact and Proposed Findings of Fact are incorporated by reference into the body of this document as if set forth in full. *See* attached ALJ Proposed Decision, Exhibit 1. The factual findings were proven by a preponderance of the evidence. In sum, the Panel finds that Dr. Mintz failed to meet the appropriate standard of care for eight out of ten patients reviewed and failed to keep adequate medical records for all ten patients reviewed.

Specifically, pertaining to the standard of care, Dr. Mintz: failed to have patients sign an opioid agreement prior to starting or continuing opioid therapy; failed to assess patients for functional benefit from opioid medication prior to starting opioid therapy: prescribed high-dose opioids without attempting to treat patients with non-opioid therapies for pain; prescribed high-dose opioids even though the patient had not been routinely seen for re-evaluation; failed to utilize urine toxicology screenings or other compliance measures: prescribed benzodiazepines to patients who were prescribed high-does opioids without recognizing the risks or conveying the risk to the patients; and failed to consider or refer patients to a pain specialist when the patients'

pain was not controlled by opioids or discharge or refer a patient elsewhere if there were signs of opioids abuse or misuse.

Pertaining to his recordkeeping, Dr. Mintz failed to record adequate information to justify the high dose opioids that he prescribed; prescribed opioids without a documented office visit; and failed to document efforts to monitor compliance.

CONCLUSIONS OF LAW

Pursuant to the stipulated conclusions of law, the Panel concludes that Dr. Mintz failed to meet the standard of care, in violation of Health Occ. § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40).

SANCTION

Dr. Mintz does not object to most of the proposed sanction recommended by the ALJ. The ALJ recommended, and Dr. Mintz does not object to, a reprimand, probation, a course in medical recordkeeping, a $1,000 fine, and a permanent prohibition on prescribing and dispensing opioids. These sanctions were based on the conclusion that Dr. Mintz's opioid prescribing was below the standard of care and potentially dangerous. The Panel adopts those sanctions.

Dr. Mintz objects to a permanent prohibition on his certifying patients for cannabis. The ALJ noted that there was no data supporting Dr. Mintz's position that medical cannabis decreased dependence on opioids and noted that Dr. Mintz's patients who were using opioids did not reduce their use of opioids when they were certified for cannabis. The ALJ noted concerns that there was inadequate monitoring of patients on chronic opioid treatment by Dr. Mintz and concluded that this deficiency suggested inadequate follow-up care. The ALJ also expressed concern that in a solo concierge practice there are justifiable concerns for public safety if Dr. Mintz were to continue to certify patients for cannabis.

Dr. Mintz argued, in his exceptions, that the qualifying conditions for medical cannabis are not solely pain, but include anorexia, severe nausea, seizures, severe or persistent muscle spasms, glaucoma, and PTSD, as well as anxiety and insomnia. Dr. Mintz pointed out that his certification for cannabis included a medical consultation with a patient history and often a physical examination. Dr. Mintz further noted the low medical risks for use of cannabis and noted the differences between the serious risks for opioid prescribing and the lesser risks for cannabis use. Further, Dr. Mintz noted the mitigating factors, including the absence of a prior disciplinary record, his full cooperation during the proceedings, his implementation of remedial measures, his good faith efforts to rectify consequences, a showing of rehabilitative potential, and the lack of patient harm. Dr. Mintz also argued that the peer reviewers had no concerns or issues with his medical cannabis practice.

In response, the State focused on Dr. Mintz's financial motivations for his cannabis certification practice. The State also stated that patients did not decrease opioid use when he certified them for cannabis.

Dr. Mintz demonstrated to the Panel a strong grasp of the medical issues related to cannabis certification, both in terms of his significant knowledge regarding the biological effects of how the body reacts to cannabis and demonstrated knowledge about the various conditions for which cannabis is certified. He also demonstrated significant experience in certifying patients for cannabis, including seeing about 500 patients per year for certification or recertification for several years. Unlike physicians who inappropriately prescribe opioids in a "pill mill" for profit and then, after the Board removes that option, seek to substitute cannabis as another controlled dangerous substance that is easy to profit from, Dr. Mintz showed interest and experience in

cannabis before the complaint in this case was filed and has demonstrated interest in the field far beyond a mere profit motive.

Dr. Mintz took continuing education trainings, attended workshops and lectures, and has significant and lengthy experience in cannabis certification through his own practice. While Dr. Mintz's opioid prescribing was below the standard of care, the Panel has no such concern for his cannabis certification practice.

Based on the forgoing, the Panel grants Dr. Mintz's exception and will not impose a permanent prohibition on certifying patients for cannabis.

ORDER

It is, by an affirmative vote of a majority of a quorum of Disciplinary Panel A, hereby

ORDERED that Matthew Mintz, M.D. is **REPRIMANDED**; and it is further

ORDERED that Dr. Mintz is **PERMANENTLY PROHIBITED** from dispensing or prescribing opioids; and it is further

ORDERED that on every January 31st thereafter if Dr. Mintz holds a Maryland medical license, Dr. Mintz shall provide the Board with an affidavit verifying that he has not prescribed opioids in the past year; and it is further

ORDERED that if Dr. Mintz fails to provide the required annual verification of compliance with this condition:

(1) there is a presumption that Dr. Mintz has violated the permanent condition; and

(2) the alleged violation will be adjudicated pursuant to the procedures of a Show Cause Hearing; and it is further

ORDERED that Dr. Mintz is placed on **PROBATION** until the following probationary terms and conditions have been met:

1. Within **SIX (6) MONTHS**, Dr. Mintz is required to take and successfully complete a course in medical recordkeeping. The following terms apply:

   (a) It is Dr. Mintz's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the course before the course is begun;

   (b) Dr. Mintz must provide documentation to the disciplinary panel that he has successfully completed the course;

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

   (d) Dr. Mintz is responsible for the cost of the course.

2. Within **SIX (6) MONTHS**, Dr. Mintz shall pay a $1,000 fine to be paid by certified check or money order payable to The Maryland Board of Physicians, 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, after Dr. Mintz has complied with all terms and conditions of probation, Dr. Mintz may submit a written petition for termination of probation. Dr. Mintz's probation may be administratively terminated through an order of the disciplinary panel if Dr. Mintz has complied with all probationary terms and conditions and there are no pending complaints relating to the charges; and it is further

ORDERED that Dr. Mintz is responsible for all costs incurred in fulfilling the terms and conditions of this Final Decision and Order; and it is further

ORDERED that, if Dr. Mintz allegedly fails to comply with any term or condition imposed by this Final Decision and Order, Dr. Mintz 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, Dr. Mintz 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 Dr. Mintz has failed to comply with any term or condition imposed by this Final Decision and Order, the disciplinary panel may reprimand Dr. Mintz, place Dr. Mintz on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke Dr. Mintz'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 Dr. Mintz; and it is further

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

11/09/2022
Date

Signature On File

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

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 14-408(a), Dr. Mintz has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within 30 days from the date of mailing of this Final Decision and Order. The cover letter accompanying this Final Decision and Order indicates the date the decision is mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Dr. Mintz files a petition for judicial review, the Board is a party and should be served with the court's process at the following address:

Maryland State Board of Physicians
Christine A. Farrelly, Executive Director
4201 Patterson Avenue
Baltimore, Maryland 21215

Notice of any petition should also be sent to the Board's counsel at the following address:

David S. Finkler
Assistant Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

Exhibit 1

MARYLAND STATE BOARD OF	*	**BEFORE ANN C. KEHINDE,**
PHYSICIANS	*	**AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE**
MATTHEW MINTZ, M.D.,	*	**OF ADMINISTRATIVE HEARINGS**
RESPONDENT	*	
LICENSE No.: D72166	*	**OAH No.: MDH-MBP2-71-21-28039**

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PROPOSED DECISION

SUMMARY

The Respondent Physician stipulated that he failed to meet the standard of care and to keep adequate medical records for a group of his patients suffering from chronic noncancer pain (CNCP) and on chronic opioid treatment (COT). He agreed to be permanently barred from prescribing or dispensing opioids.

The Respondent also sees patients to determine whether they should be certified to use medical cannabis. The Maryland State Board of Physicians (Board) sought a permanent prohibition on the Respondent's certification of patients for the use of medical cannabis to which the Respondent objected. Based on the Respondent's serious failure to meet the standards of care and the inadequacy of his medical record keeping, the Board's permanent prohibition on the

Respondent's certification of patients for medical cannabis should be upheld along with its requested Reprimand, Probation, and a civil fine in the amount of $1,000.00.

STATEMENT OF THE CASE

On October 8, 2021, the Maryland State Board of Physicians (Board) issued charges against Matthew Mintz, M.D. (Respondent), for alleged violations of the State law governing the practice of medicine. Md. Code Ann., Health Occ. §§ 14-101 through 14-508, and 14-601 through 14-607 (2021). Specifically, the Respondent is charged with violating section 14-404(a)(22) "fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State;" and section 14-404(a)(40) "fails to keep adequate medical records as determined by appropriate peer review." Code of Maryland Regulations (COMAR) 10.32.02.03E(3)(d).

The disciplinary panel to which the complaint was assigned held a meeting with the Respondent on November 17, 2021, to explore the possibility of resolution. COMAR 10.32.02.03E(9). The parties did not resolve the issues at that time. On December 9, 2021, the matter was forwarded to the Office of Administrative Hearings (OAH). The matter was delegated to the OAH for issuance of proposed findings of fact, proposed conclusions of law, and a proposed disposition. COMAR 10.32.02.03E(5); COMAR 10.32.02.04B(1).

On January 7, 2022, I held a remote Scheduling Conference and on January 28, 2022, I issued a Scheduling Order. Among the various issues discussed, the parties agreed to hold a Prehearing Conference on March 8, 2022, and a hearing on the merits on April 11 and 12, 2022.

On March 4, 2022, the parties filed Stipulations as to Findings of Fact, Conclusions of Law, and Exhibits. The parties further requested that the Prehearing Conference scheduled for March 8, 2022 be cancelled; I granted the request.

On April 11, 2022, I held a hearing on the merits by Webex. Health Occ. § 14-405(a); COMAR 10.32.02.04; COMAR 28.02.01.20B. Kelly Cooper, Assistant Attorney General and Administrative Prosecutor, represented the State of Maryland (State). Robert Maynard, Esquire, represented the Respondent, who was present.

Procedure is governed by the contested case provisions of the Administrative Procedure Act, the Rules for Hearings Before the Board of Physicians, and the Rules of Procedure of the OAH. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2021); COMAR 10.32.02; COMAR 28.02.01.

ISSUE

What sanctions are appropriate for the Respondent's violations of section 14-404(a)(22)(failing to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State) and section 14-404(a)(40)(failing to keep adequate medical records as determined by appropriate peer review) of the Health Occupations Article of the Maryland Annotated Code?

SUMMARY OF THE EVIDENCE

Exhibits

The parties stipulated to the authenticity and admissibility of thirty-one Board exhibits. They are listed in an addendum to this Proposed Decision.

The parties stipulated to the authenticity and admissibility of three Respondent exhibits. They are listed in an addendum to this Proposed Decision.

Testimony

No witnesses testified on behalf of the Board.

The Respondent testified in his own behalf and did not present any other witnesses.

STIPULATIONS OF FACT

The parties having stipulated, the following facts are found by a preponderance of the evidence:[1]

I. Background

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on April 22, 2011, under License Number D72166. The Respondent's license is currently active and scheduled to expire on September 30, 2023.
2. The Respondent is board-certified in internal medicine.
3. At all times relevant hereto, the Respondent was the sole owner of a primary care practice that provides concierge services (the "Practice").

II. The Complaint

4. On or about November 20, 2020, the Board received an anonymous complaint alleging the Respondent is overprescribing controlled dangerous substances ("CDS") to a patient ("Patient 1") without proper evaluation.

[1] The Stipulated Findings of Fact have not been edited and are presented exactly as submitted by the parties.

III. Board Investigation

5. Based on the Complaint, the Board initiated an investigation under case number 2221-0069B.

6. As part of its investigation, the Board obtained a series of patient records, interviewed the Respondent, and obtained a peer review of the Respondent's care of ten patients.

A. Patient Records

7. By letter dated January 8, 2021, the Board notified the Respondent that it had opened an investigation of the matter and provided the Respondent with a copy of the Complaint. The Board directed the Respondent to provide a response to the allegations raised in the Complaint.

8. On January 8, 2021, the Board also issued the Respondent a Subpoena Duces Tecum that directed the Respondent to transmit to the Board "a complete copy of any and all medical records" for ten specific patients ("Patients 1-10") that "are in [the Respondent's] possession or [the Respondent's] constructive possession and control, whether generated by [the Respondent] or any other health care entity."

9. The Respondent transmitted to the Board medical records, a summary of patient care, and a Certification of Medical Records that the Respondent signed for all ten patients certifying that he had provided the Board with "the complete medical records which include all records pertaining to the care and treatment" of all ten patients.

B. Interview of the Respondent

10. On March 8, 2021, Board staff interviewed the Respondent under oath, during which the Respondent stated the following:

a. He is the sole owner of his primary care practice which offers concierge services. He does not take insurance. Instead, patients pay a fee either annually, monthly, or quarterly, to cover primary care services as well as same-day appointments, next day appointments, and 24/7 phone access.

b. As part of his practice, he is also a certified provider for medical cannabis, a treatment center for Spravato[2], and his medical assistant can draw bloodwork which is sent to a laboratory for processing and billing insurance for the patients.

c. He has about 70-80 patients with chronic pain. He manages the chronic pain aspect of approximately 40 of these patients. He only manages the primary care aspect of the others.

d. He admitted that he does not use urine drug screens.

e. He admitted that he does not use drug contracts – "I do that verbally. . . . basically letting them know that if I'm going to prescribe controlled substances that, you know, I'm the only one that can – they can't see other doctors for controlled substances as well."

f. He stated that when most of his patients first come to him they are already on narcotics and "I'm not determining whether they should be prescribed narcotics. I'm determining is this -- is the narcotic regimen that they're currently on appropriate."

[2] Spravato is a nasal spray that is used to treat depression and is administered only in a healthcare setting.

C. Peer Review

11. In furtherance of its investigation, the Board submitted the records of Patients 1-10 and related materials to a peer review entity to determine if the Respondent complied with appropriate standards for the delivery of quality medical care and kept adequate medical records. Two peer reviewers, each board-certified in pain management, independently reviewed the materials and submitted their reports to the Board.

12. In their reports the two physician peer reviewers concurred that the Respondent failed to meet appropriate standards for the delivery of quality medical care for eight (8) out of ten (10) patients (Patients 1, 2, 3, 4, 5, 6, 9, and 10), in violation of Health Occ. § 14-404(a)(22). The peer reviewers further concurred that the Respondent failed to keep adequate medical records for all ten patients, in violation of Health Occ. § 14-404(a)(40).

13. Specifically, the peer reviewers found that for eight of the ten patients, the Respondent failed to meet the standard of quality medical care for reasons including but not limited to the following:

a. The Respondent failed to have patients sign an opioid agreement/contract prior to starting or continuing opioid therapy. *See* e.g., Patients 1, 2, 3, 4, 5, 6, 9, 10.

b. The Respondent failed to assess for functional benefit from opioid medications prior to starting or continuing opioid therapy. *See* e.g., Patients 1, 2, 6.

c. The Respondent prescribed/continued to prescribe high-dose opioids without attempting to treat the patients with non-opioid therapies for pain (e.g., physical therapy, acupuncture, cognitive behavioral therapy, non-opioid medications, etc.). *See* e.g., Patients 1, 5, 6, 9.

d. The Respondent prescribed/continued to prescribe high-dose opioids even though the patient had not been routinely seen for re-evaluation. *See* e.g., Patients 1, 2, 3, 4, 5, 6, 9, 10.

e. The Respondent failed to utilize urine toxicology screening or other compliance measures with patients. *See* e.g., Patients 1, 2, 3, 4, 5, 6, 9, 10.

f. The Respondent prescribed benzodiazepines to patients who were also prescribed high-dose opioids without recognizing the risks and conveying the risks to the patient. *See* e.g., Patients 1 (alprazolam and oxycodone), 2 (alprazolam and OxyContin), 6 (alprazolam, OxyContin, and oxycodone).

g. The Respondent failed to consider or refer patients to pain specialists when the patient's pain was not controlled by opioids or discharge or refer a patient elsewhere if there were signs of opioid abuse or misuse or offer a trial of evidence-based treatment for those with opioid use disorder. *See* e.g., Patients 1, 2, 5.

14. The peer reviewers also found that for all ten of the patients, the Respondent failed to maintain adequate medical records for reasons including but not limited to the following:

a. The Respondent failed to provide enough information regarding justification for the high dose opioids the Respondent prescribed to the patients. *See* e.g., Patients 1, 2, 3, 4, 5, 6, 8, 9, 10.

b. The Respondent prescribed opioids without a documented office visit. *See* e.g., Patients 1, 2, 3, 4, 5, 6, 7, 9, 10.

c. The Respondent failed to document efforts to monitor compliance (e.g., signed opioid agreement/contracts, urine toxicology screens, etc.). *See* e.g., Patients 1, 2, 3, 4, 5, 6, 7, 9, 10.

D. The Respondent's Response

15. The Board provided the Respondent with the peer reviewers' findings. By letter dated August 3, 2021, the Respondent submitted his response. As part of his written response, the Respondent stated, in part, "In light of the peer reviewers' comments, and after reviewing my patient population, I intend to stop treating chronic pain patients. I am in the process of notifying those patients (approximately 35) that I intend to see them and/or prescribe for them for chronic pain only for an additional 90 days."

PROPOSED FINDINGS OF FACT

Having considered all of the evidence presented, I further find the following facts by a preponderance of the evidence:

1. The Respondent's concierge practice is made up of three subgroups of patients: patients who are administered Spravato and are monitored in his office; patients who are seeking a certification for medical cannabis; and patients who need an internal medical doctor to coordinate their care, see them for annual physicals and provide care when they are sick.

   a. Spravato is prescribed to patients with depression who have not responded well to the typical psychotropic medications commonly used to treat depression. Spravato must be administered in a medical office because the patient must be monitored for a period of time after the Spravato is administered. For those patients who are just receiving Spravato, the Respondent does not see them for other medical concerns, and they are not "members" who pay a membership fee; instead, they pay a fee for the monitoring services of being administered Spravato on a weekly basis.

   b. Patients are self-referred to the Respondent or by their physicians to determine if they meet the certification requirements for medical cannabis. They pay cash for the

once per year certification but can pay an additional fee for follow-up visits if they choose to do so.

c. Patients pay a fee of $1,750.00 per year to be a member of the Respondent's concierge practice. The Respondent does not accept any form of insurance. Once the fee is paid (annually, quarterly or monthly) they are entitled to same-day, next-day or telemedicine appointments. During the COVID-19 pandemic, the Respondent has encouraged telemedicine unless the person needed a pre-operative physical, or a physical in general, which cannot be accomplished through telemedicine.

2. When the Board began its investigation of the Respondent, approximately forty of his patients suffered from CNCP and used opioid analgesics for the chronic pain. These patients came to the Respondent for treatment in a variety of ways. Some began seeing the Respondent because their physician or pain management specialist was retiring, and they needed to find a new doctor, or they had moved to the area and needed a new doctor. Some came to the Respondent because they wanted to try medical cannabis to see if it would help with their CNCP. Physicians for many CNCP patient on COT will not continue to prescribe opioids if these patients test positive for cannabis. For those patients, the Respondent agreed to continue prescribing opioids if they became a patient in his practice and were not just seen for medical cannabis certification.

3. Morphine Milligram Equivalents (MME) is a value that compares the potency of a specific opioid to the potency of morphine.

4. Clinicians should prescribe the lowest effective dosage of opioids. When increasing the dosage to 50 MME or greater per day, the physician must carefully reassess the evidence of benefit versus the possible risks to the individual and communicate that information to the

patient. Physicians should avoid increasing the dosage to 90 MME or greater per day; if a physician does prescribe a dosage of 90 MME or greater per day, the physician must carefully justify his decision.

5. At least every three months a physician should evaluate the benefits and harms of continued COT.

6. Patients who are 65 years of age or older have increased susceptibility to accumulation of opioids and a smaller therapeutic window between safe dosage and dosages associated with respiratory depression and overdose.

7. Patients who have a sleep disorder are more susceptible to opioid overdose. A patient with a mild sleep disorder must be carefully monitored on opioids. Opioids should be avoided whenever possible for patients with a moderate to severe sleep disorder.

STIPULATED CONCLUSIONS OF LAW

Based on the stipulated Findings of Fact, the parties stipulated that as a matter of law, the Respondent's actions constitute violations of the following provisions of the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §14-404(a):

> 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:
>
> . . . .
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State;
>
> . . .
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

DISCUSSION OF PROPOSED SANCTION

The Board seeks to impose the following disciplinary sanctions against the Respondent: (1) A permanent prohibition on prescribing and dispensing opioids; (2) A permanent prohibition on certifying patients for medical use of cannabis; (3) A Reprimand; (4) Probation for six months during which time the Respondent must (a) pay a civil fine of $1,000.00 and (b) successfully complete a Board-approved course in record keeping. Md. Code Ann., Health Occ. § 14-404(a) (2021); COMAR 10.32.02.09A-B; COMAR 10.32.02.10.

Although a permanent prohibition on the prescribing and dispensing of opioids is not specifically stated as a possible sanction, the regulations provide that a sanction "may be accompanied by conditions reasonably related to the offense or to the rehabilitation of the offender." COMAR 10.32.02.09A(5). In this case, a permanent prohibition on the prescribing and dispensing of opioids is reasonably related to the Respondent's offense of failing to meet the standards of care. Further, COMAR 10.32.02.09A(4) provides that more than one sanction may be imposed as long as the most severe sanction neither exceeds the maximum nor is less than the minimum sanction permitted in the chart.

The Respondent is not opposed to a permanent prohibition on prescribing and dispensing opioids. The Respondent testified that after he received the peer reviewers' comments, he evaluated his practice and decided to only continue treating his pain patients for ninety days and by the end of that ninety days he found pain management specialists or doctors to whom to transfer each of those patients. As a result, he has no plans to prescribe opioids in the future and therefore he does not object to a permanent prohibition on prescribing and dispensing opioids.

Although the Respondent decided to stop treating pain patients and agreed to a permanent ban on prescribing opioids, a closer review of the exhibits demonstrates that the stipulated facts,

without elaboration, do not sufficiently convey the serious potential for harm caused by the Respondent's care of patients on COT.

The initial complaint against the Respondent came from an emergency room clinician who was concerned that on November 17, 2020, a patient, A.S., came in seeking pain medication for her chronic pain. The clinician reviewed the Chesapeake Regional Information System for Our Patients (CRISP) which is a platform from which providers can access the Prescription Drug Monitoring Program (PDMP). From this review, the clinician could see that A.S. had "received an abundant supply of narcotics in the past several weeks, and from several different pharmacies[.]" (Bd. Ex. 1, p. 3). Based on this review, and A.S.'s comment that she does not see the "concierge doctor in person, I just call in and he prescribes my pain pills," the emergency room provider was "very concerned that patient is being overprescribed narcotics and not having proper evaluation before being prescribed." (Bd. Ex. 1, p. 3). Although the Respondent contradicted A.S.'s statement that she can just call in and he refills her "pain pills," the record demonstrates that the reality was closer to A.S.'s version of events.

A.S. became the Respondent's patient on February 5, 2020, and he saw her for an office visit on that date and on February 24, 2020. After an office visit on June 24, 2020, the Respondent did not see her for any office visits prior to her trip to the emergency room on November 17, 2020 – a period of almost five months. The month prior to her trip to the emergency room, the patient called the Respondent's practice to say that she had "lost" all of her medication the night before[3] and the day before she went to the emergency room, she called to report that her "medication was stolen again by her daughter."[4] There is no documentation in the patient's chart that A.S. told the Respondent that she went to the emergency room on November

[3] Bd. Ex. 10(a)(ii), MM0095.
[4] Bd. Ex. 10(a)(ii), MM092.

17, 2020, so I assume she did not tell the Respondent. On December 8, 2020, the Respondent called in medications for A.S. and on January 6, 2021, there is a message in A.S.'s chart that she called to say that when she went to the emergency room, they "flushed her pills." (Bd. Ex. 10(a)(ii), MM0086). As of January 18, 2021, when the Respondent certified A.S.'s record[5], there is no documentation that A.S. had an office visit or a telemedicine visit in the past seven months, despite reports from A.S. of stolen and lost prescriptions, as well as at least one trip to the emergency room. Further, although neither reviewer noted this, there is a letter from the Respondent in A.S.'s medical record dated January 11, 2021, stating that she has a "sleep disorder (likely sleep apnea) that severely impairs her wakefulness during the day." (Bd. Ex. 10(a)(ii), MM0097). The Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain cautions that "careful monitoring and cautious dose titration should be used if opioids are prescribed for patients with mild sleep-disordered breathing. Clinicians should avoid prescribing opioids to patients with moderate or severe sleep-disordered breathing whenever possible to minimize risks for opioid overdose." (Bd. Ex. 30, p. 453). Despite the Respondent's diagnosis of a sleep disorder, he made no effort to determine whether she had a mild, moderate, or severe sleep disorder and he did not carefully or closely monitor A.S.

The Respondent noted that he did not see as many patients in-person due to the COVID-19 Pandemic and that A.S. was unable to have virtual visits given her lack of housing and resources. Although those issues were clearly obstacles to seeing A.S. in-person, many of the Respondent's other CNCP patients were not monitored for significantly longer periods of time than the three months or fewer which is recommended by the CDC Guideline for Prescribing Opioids for Chronic Pain (2016). (Bd. Ex. 30, p. 443).

[5] Bd. Ex. 10(a)(i), MM0044.

Although the Respondent noted that he was aware of the potential for diversion of prescribed opioids, and that he did not believe A.S. was in that category, he provided no reasoning for his belief.[6] An independent reviewer, Dr. Larkin, provided a detailed reason as to why the possibility should have been explored:

> The Respondent is clearly not aware of the documentation requirements and guidelines associated with prescribing opioids. It's concerning when you have a concierge doctor who seems to write for controlled medications on demand, without the typical cautionary steps. He needs to be aware that the street value of the drugs he writes for would easily pay for the $1750 a year that he charges this indigent patient for care. The CDC estimates that the value of a 15 mg oxycodone pill is $20. He writes for 240 pills a month, 2880 pills a year, for a net value of $57,600. This would easily cover the costs, even if she used a small fraction of her prescribed doses.
>
> (Ex. 18, p. 141).

Unfortunately, the potential for A.S. to overdose, or to divert opioids to the street market, was not an outlier.[7] Many of the other patients whose charts the independent experts reviewed were on extremely high doses of COT. The Respondent noted that he was not the original prescribing physician for any of these patients and that they were already on these dosages when he took over their care.[8] However, the guidelines clearly state that assessment of risk versus benefit is an ongoing evaluation a prescriber of opioids must make and document for each patient.

The reviewers were aware that in many cases the patients came to the Respondent already on very high levels of opioids; unlike the Respondent, they disagreed that there was nothing he

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[6] In his response, the Respondent wrote, "I do not find her behavior to be that of the typical drug seeking patient whose prescriptions tend to be mysteriously stolen and who is then is [sic[in need of more medication." (Bd. Ex. 24, p. 251). The Respondent does not describe what a "typical" drug seeking patient is or how he would identify one.

[7] Dr. Larkin summarizes the Respondent's care of Patient K.H. as seeing his "patients annually, writes opioid medications sight unseen, and makes minimal efforts to check compliance." (Board Ex. 19, p. 148).

[8] Patient A.S. (Bd. Ex. 24, p. 251); Patient C.A. (Bd. Ex. 24, p. 251); Patient V.D. (Bd. Ex. 24, p. 251); Patient R.L. (Bd. Ex. 24, p. 252); Patient S.N. (Bd. Ex. 24, p. 253); and Patient R.W. (Bd. Ex. 24, p. 253).

could do but continue their high level of opioid dosage. K.H. is a good example.[9] She came to the Respondent after her pain physician retired. After her doctor retired, no one would accept her as a new patient, and she stretched her medication out for months. The independent expert, Dr. Larkin, noted that K.H. did not have any prescriptions filled from September 14, 2017, until she was seen by the Respondent on April 20, 2018. (Bd. Ex. 18, p. 148). Despite being on low doses or no doses of opioids, Dr. Larkin noted that the Respondent put her back on high doses of opioids "without question despite the clear risk of overdose in this situation." (Bd. Ex. 18, p. 148). Dr. Larkin described the resumption of opioids prescribed for K.H. as a "mind boggling dose of opioids, with a mix of Methadone, Dilaudid oral, and Dilaudid intramuscular (IM), and soma for good measure. Her MME is 2,184 by my best calculation using the CDC dose calculator." (Bd. Ex. 18, p. 148).

Dr. Larkin rightly blamed K.H.'s prior doctor: "While the prior doctor who retired after creating this mess holds a lot of the responsibility, I think she would have been better off if nobody had taken her case, unless she was supplementing with street drugs during the period when she was without a doctor, but without a routine drug screen at the initial visit, we will never know." (Bd. Ex. 18, p. 150).

The Board's second independent expert, Dontese Nicholson, M.D., also expressed alarm at the Respondent's prescribing and concomitant lack of monitoring of patient K.H.:

> The use of hydromorphone injection on an outpatient basis is highly unusual. This is not an option that I could imagine a reasonable internal medicine physician, or a fellowship trained pain medicine specialist would ever use even under the most extreme circumstances, including end of life care. Even if this was used by the prior provider, it should not have been restarted. This patient should have been monitored more frequently – daily or weekly given the regimen prescribed. Urine toxicology screening was not performed. A note indicated that the respondent called in this extreme regimen of controlled dangerous substances

[9] The Respondent treated two patients with the initials K.H. This is K.H. with a date of birth of December 6, 1971.

but has not seen the patient for over a year. Essentially the patient was not monitored.

(Bd. Ex. 20, p. 182).

The lack of monitoring of K. H. cannot be blamed on the pandemic. K.H.'s first appointment with the Respondent was on April 20, 2018, and she saw the Respondent again five months later. However, after that appointment, she did not see the Respondent either in-person or by telemedicine until April 10, 2020 – nineteen months later. (Bd. Ex. 10(e)(ii), MM0602).

The Respondent did not see another patient, V.D., for fourteen months. Although some of this time was during the pandemic (November 2019 to January 2021), the Respondent did not explain why he did not see V.D. in a telemedicine appointment during that time period. Dr. Larkin opined that "[t]his is pretty unacceptable for a patient with an MME of 630." (Bd. Ex. 18, p. 145).

Although the Respondent acknowledged that his practice did not meet the appropriate standards, and that his medical records were inadequate, he did not answer the question as to *why* he practiced in this manner. Dr. Larkin opined that the Respondent "has obviously not been to conferences that address the current expectations when prescribing opioids. This is true also for simply reviewing the CDC prescribing guidelines.... He also does not seem to have a grasp on the risks of abuse and diversion and the potential risks of the doses for which he is writing." (Bd. Ex. 18, p. 160). Given the Respondent's background, his manner of practice is extremely puzzling. The Respondent is not an inexperienced clinician. He was a full-time faculty member at a major teaching hospital for nineteen years; splitting his time between teaching medical students (and some residents) as well as seeing patients. (Bd. Ex. 12, p. 45). He is certified by the American Board in Internal Medicine and has completed his continuing medical education for the American Medical Association every three years since 1998. (Resp. Ex. 1).

A clue to why, or what caused the Respondent to practice the way he did, was provided by Dr. Larkin: "I think the main issue, however is the idea of a 'concierge practice.' He seems to equate the fact that he does not bill insurance companies with the idea that documentation and follow-up are of lesser importance. This is obviously and painfully not true, especially when prescribing opioids and other narcotics." (Bd. Ex. 18, p. 160-1).

Dr. Larkin's conclusion is supported by the differences in the way the Respondent treated Patient C.A. when C.A. was his patient at the teaching hospital, with the way the Respondent treated C.A. as part of his concierge practice. Dr. Larkin does not necessarily fault the Respondent for the high doses of opioids because he notes that the dosages were escalated, after multiple other interventions were unsuccessful, by the pain clinic at the teaching hospital before the Respondent took over C.A.'s care in 2010. On the other hand, he notes the lack of medical record documentation and monitoring have nothing to do with the original prescribing by the pain clinic at the teaching hospital:

> While at [the teaching hospital, the Respondent] does a great job of documenting not just [C.A.'s] medical problems but also other efforts to treat the pain. Once [the Respondent] leaves [the teaching hospital], this detailed documentation is lost. He seems to have few visits with the patient and the majority of interactions are over the phone with the patient or his wife.

(Bd. Ex. 18, p. 142).

The Respondent also testified that he treated the CNCP patients with medical cannabis with the laudable goal of reducing their opioid use. He further testified that he was successful in doing that for many of his patients. Dr. Larkin disputed the Respondent's assertion:

> I reviewed the patient's CRISP report, and it does not match [the Respondent's] narrative in his notes. The patient had his medications filled every month, and never decreased despite the claims that this happened after starting cannabis. While under the care of [the Respondent], the patient's MME essentially doubled to 150 MME. I have reviewed the CRISP on all of the patients, and I did not see

> decreases in opioid prescribing in any of them after starting cannabis. Most of the time, the dose remained stable or increased.

(Bd. Ex. 18, p. 158).

I have given great weight to Dr. Larkin's conclusion that the dosages of opioids prescribed for patients did not decrease after the patients were started on medical cannabis for several reasons. The Respondent received the peer reviewers' reports and knew that Dr. Larkin based his conclusion on both his records and reviews of the PDMP reports. In the Respondent's August 3, 2021 response to the Board, the Respondent did not challenge Dr. Larkin's conclusion or point to data from the PDMP reports to support his position that the dosages of opioids decreased. (Bd. Ex. 24B). Similarly, during his testimony the Respondent did not point to specific data to support his position that patients decreased their MME with the introduction of medical cannabis.

Further, although I note that Dr. Nicholson stated that "in some instances, the respondent has even achieved reduction of medications with the use of medical cannabis," (Bd. Ex. 20, p. 193), a reduction of medications is not the same as a reduction of opioids with its risk of overdose. For example, Patient R.L. was able to discontinue benzodiazepines with the use of medical cannabis (Bd. Ex. 20, p. 184), but benzodiazepines are not opioids.[10] Dr. Nicholson did not state that he reviewed the PDMP reports so I do not know whether his opinion was the result of his independent review or based on the Respondent's assertions.

The fact that the Respondent was not able to reduce his patients' dependence on opioids by the introduction of medical cannabis is relevant to the determination of the reasonableness of the Board's proposed prohibition on the Respondent's certification of patients for medical

[10] This is not to minimize the benefit to the patient from being able to discontinue the benzodiazepines. The CDC guidelines provide that clinicians should "avoid prescribing opioid pain medications and benzodiazepines concurrently whenever possible" because of the greater risk of overdose. (Bd. Ex. 30, p. 443).

cannabis.[11] If, as the Respondent asserted, he was able to reduce his patient's dependence on opioids by his practice of certifying them for medical cannabis, that would be one factor persuading me that it would be unreasonable to prohibit him from continuing to certify patients for medical cannabis.

The Respondent testified that he has taken the time and effort to thoroughly learn about the medical uses of cannabis and that he goes into much more detail than other certifying health professionals in that he specifically recommends a dispensary that has a good reputation and will have the specific type of medical cannabis that he believes will benefit the patient. He further explains to the patient what strain and type of medical cannabis the patient should ask for and how the patient should titrate the amount of cannabis he or she uses. He is available (for a further fee) if the patient wants to schedule a follow-up visit.

In Maryland, a "certifying provider" of medical cannabis includes an individual who has an active, unrestricted license to practice medicine that was issued by the State Board of Physicians and is in good standing with the Board. Md. Code Ann., Health-Gen. § 13-3301(d)(1)(i). The statute also provides that the physician must also have a State controlled dangerous substances registration; and be registered with the Natalie M. Laprade Medical Cannabis Commission (Commission) to make cannabis available to patients for medical use in accordance with regulations adopted by the Commission. Md. Code Ann., Health-Gen. § 13-3301(d)(2) and (d)(3).[12]

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[11] Again, although a prohibition on certifying patients for medical cannabis is not specifically provided for as a sanction in the regulations, a sanction "may be accompanied by conditions reasonably related to the offense or to the rehabilitation of the offender." COMAR 10.32.02.09A(5).

[12] I question how the Respondent, with a reprimand and a probation on his record, would be considered a physician in good standing without a restricted license, but the scope of whether he meets the requirements of the Commission is not before me. Similarly, I question how the Respondent would qualify for a State controlled dangerous substance registration if he has a permanent prohibition on prescribing and dispensing opioids, but that is also not an issue for me to decide.

A "qualifying patient" who wishes to be certified for medical cannabis in Maryland must see a certifying provider and obtain a "written certification." A "written certification" means a certification that:

> (1) Is issued by a certifying provider to a qualifying patient with whom the provider has a bona fide provider-patient relationship;
> (2) Includes a written statement certifying that, in the provider's professional opinion, after having completed an assessment of the patient's medical history and current medical condition, the patient has a condition:
> (i) That meets the inclusion criteria and does not meet the exclusion criteria of the certifying provider's application; and
> (ii) For which the potential benefits of the medical use of cannabis would likely outweigh the health risks for the patient; and
> (3) May include a written statement certifying that, in the provider's professional opinion, a 30-day supply of medical cannabis would be inadequate to meet the medical needs of the qualifying patient.

Md. Code Ann., Health-Gen. § 13-3301(p).

Further, a certifying provider must include the following in the "proposal" to the Commission that the patient be certified:

> (1) The reasons for including a patient under the care of the provider for the purposes of this subtitle, including the patient's qualifying medical conditions;
> (2) An attestation that a standard patient evaluation will be completed, including a history, a physical examination, a review of symptoms, and other pertinent medical information; and
> (3) The provider's plan for the ongoing assessment and follow-up care of a patient and for collecting and analyzing data.

Md. Code Ann., Health-Gen. § 13-3304(b).

Finally, regulations were promulgated to implement the purposes of the Commission, including COMAR 10.62.01.01B(4) which defines a "bona fide provider-patient relationship" as:

> (4) ... a treatment or counseling relationship between a provider and a patient in which the provider has:
>
> (a) Reviewed the patient's relevant medical records and completed an in person assessment of the patient's medical history and current medical condition;

(b) Created and maintained records of the patient's condition in accord with medically accepted standards; and

(c) A reasonable expectation that the provider will monitor the progress of the patient while using medical cannabis and take any medically indicated action:

(i) To provide follow-up care to the patient;

(ii) Regarding the efficacy of the use of medical cannabis as a treatment of the patient's severe or debilitating medical condition; and

(iii) Regarding any adverse event associated with the use of medical cannabis.

Given the Respondent's woefully inadequate monitoring of his patients on COT, there is little evidence in the medical records that he is providing follow-up care as dictated by COMAR 10.62.01.01B(4)(c). Further, given the deficiencies in his record-keeping that were noted by the reviewers, and agreed to by the Respondent, there is evidence that he is not in compliance with COMAR 10.62.01.01B(4)(b).

Further, the Administrative Prosecutor in this case argued that the Respondent should be prohibited from certifying patients for medical cannabis in order to protect the public. She argued that the Respondent started his concierge practice out of financial considerations and that he began certifying patients for medical cannabis in order to generate more business and income for his concierge practice.

The Respondent argued that the financial consideration is a red herring as all providers charge a fee to determine whether or not patients can be certified for medical cannabis. While

this is true of course, the case before me does not include the practices of other health care providers.[13] It involves the serious deficiencies of this physician as discussed in detail above. The form of the Respondent's practice – a concierge practice – in which the Respondent is the sole physician and owner does appear to have a huge role in how the Respondent became incredibly lax in actively and appropriately monitoring his patients. He did not have any oversight or input from colleagues or questions or requests to explain his rationale from insurance companies as he does not accept insurance. So, although the process is different (certification for medical cannabis as opposed to prescribing opioids) the context in which the Respondent will operate – a solo concierge practice – will remain the same. In this context, the Board is justified in its concern for the public's safety. For all of these reasons, I agree with the Board that the Respondent should be prohibited from certifying patients for medical cannabis.

I also conclude that a Reprimand of the Respondent is appropriate considering the seriousness of the Respondent's conduct as outlined and discussed above.[14]

The Board also requested that I impose Probation on the Respondent and during that time he be ordered to pay a civil fine of $1,000.00 and successfully complete a Board-approved course in record keeping. The Respondent's counsel argued that he does not usually comment on whether *de minimis* fines of $1,000.00 should be imposed but he questioned whether instead of a "probation," the Order could be worded as a "Reprimand with the Condition that the

[13] Counsel for the Respondent also argued that the public would be safer in having the Respondent, a physician with more education and medical knowledge, certify for medical cannabis than some of the other health providers permitted under the medical cannabis statutory/regulatory scheme (e.g., nurse practitioners, podiatrists, etc.). However, that issue is not for me to decide as it is the Legislature that has decided which health professionals may be certifying providers. The issue I must decide is whether the Board was reasonable in its determination to impose this sanction as it relates to the Respondent based on his actions/inactions.

[14] As noted above, more than one sanction may be imposed as long as the most severe sanction neither exceeds the maximum nor is less than the minimum sanction permitted in the chart. COMAR 10.32.02.09A(4). For failure to "meet appropriate standards as determined by appropriate peer review for the delivery of quality medical" care, under section 4-404(a)(22) of the Health-General Article, the maximum sanction that can be imposed is revocation, and the minimum is a reprimand. COMAR 10.32.02.10B(22).

Respondent complete a Board-approved course in record keeping." A $1,000.00 fine is appropriate to cover some of the costs the Board has expended in investigating the Respondent's failure to meet the appropriate standard of care (peer reviewer fees, deposition of the Respondent, etc.). I conclude it is also appropriate to impose probation on the Respondent to stress the seriousness of his failure to meet the appropriate standard of care and the deficiencies in his medical record keeping.[15]

Although counsel did not specifically argue the regulations that pertain to aggravating and mitigating factors in sanctioning physicians, I considered them when determining the proposed sanctions in this case.

COMAR 10.32.02.09B provides for aggravating and mitigating factors to be considered by disciplinary panels and administrative law judges when considering sanctions to be imposed against a physician who violates the standard of care in treating patients and maintaining adequate records.

COMAR 10.32.02.08B(5) includes, but is not limited to, the following mitigating factors:

(a) The absence of a prior disciplinary record;

(b) The offender self-reported the incident;

(c) The offender voluntarily admitted the misconduct, made full disclosure to the disciplinary panel and was cooperative during the disciplinary panel proceedings;

(d) The offender implemented remedial measures to correct or mitigate the harm arising from the misconduct;

(e) The offender made good faith efforts to make restitution or to rectify the consequences of the misconduct;

(f) The offender has been rehabilitated or exhibits rehabilitative potential;

[15] I note that COMAR 10.32.02.10B(40) provides that a $2,500.00 fine is the minimum fine for a violation of the requirement to keep adequate medical records (and $5,000.00 is the minimum fine for a violation of the requirement to meet the standards of care), but as this was not addressed during the hearing, I will accept the parties' agreement of a $1,000.00 *de minimis* fine.

(g) The misconduct was not premeditated;

(h) There was no potential harm to patients or the public or other adverse impact; or

(i) The incident was isolated and is not likely to recur.

Mitigating factors (a), (c), (d), (e), and (f) apply to the Respondent because, as noted above, the Respondent evaluated his practice after receiving the peer reviewers' reports and took corrective actions to eliminate the COT part of his practice.

I have insufficient evidence to determine whether the Respondent's conduct was premeditated as provided in COMAR 10.32.02.08B(5)(g). There is no evidence to suggest that the Respondent specifically knew that the standard of care was to have an opioid contract, require toxicology screens, and monitor the patient every three months (or more frequently), and he deliberately decided to ignore those standards in treating his patients. On the other hand, it is hard to understand how an experienced, Board-certified physician who taught medical students and residents at a well-respected teaching hospital for approximately twenty years would not have known these straight-forward and easily accessed guidelines.

COMAR 10.32.02.08B(6) includes, but is not limited to the following aggravating factors:

(a) The offender has a previous criminal or administrative disciplinary history;

(b) The offense was committed deliberately or with gross negligence or recklessness;

(c) The offense had the potential for or actually did cause patient harm;

(d) The offense was part of a pattern of detrimental conduct;

(e) The offender committed a combination of factually discrete offenses adjudicated in a single action;

(f) The offender pursued his or her financial gain over the patient's welfare;

(g) The patient was especially vulnerable;

(h) The offender attempted to hide the error or misconduct from patients or others;

(i) The offender concealed, falsified or destroyed evidence, or presented false testimony or evidence;

(j) The offender did not cooperate with the investigation; or

(k) Previous attempts to rehabilitate the offender were unsuccessful.

Only aggravating factors (c) and (d) are present in this case as there was enormous potential for great patient harm in this case, although thankfully it does not appear that any of the Respondent's patients suffered direct harm.

PROPOSED DISPOSITION

I **PROPOSE** that charges filed by the Maryland State Board of Physicians against the Respondent on October 28, 2021 be **UPHELD**; and

I **PROPOSE** that the Respondent be sanctioned by a permanent prohibition on his ability to prescribe or dispense opioids; and

I PROPOSE that the Respondent be sanctioned by a permanent prohibition on his ability to certify patients for medical cannabis; and

I PROPOSE that the Respondent be reprimanded and placed on probation, during which time he must complete a Board-approved course in medical record-keeping; and

I **PROPOSE** that the Respondent be ordered to pay a fine of $1,000.00.

[redacted]

July 5, 2022
Date Order Issued

Ann C. Kehinde
Administrative Law Judge

ACK/cj
#198303

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