IN THE MATTER OF	*	BEFORE THE
SHABNAM DADGAR, M.D.,	*	MARYLAND STATE
Respondent.	*	BOARD OF PHYSICIANS
License Number: D72779	*	Case Numbers: 2219-0008A and 2219-0067A

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

FINAL DECISION AND ORDER

PROCEDURAL HISTORY

Shabnam Dadgar, M.D., is a board-certified physician in gynecology, originally licensed to practice medicine in Maryland in 2011. On March 27, 2020, Disciplinary Panel A of the Maryland State Board of Physicians (the "Board") charged Dr. Dadgar with unprofessional conduct in the practice of medicine, gross overutilization of health care services, failure to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care ("standard of care"), and a failure to keep adequate medical records as determined by appropriate peer review.[1] *See* Md. Code Ann., Health Occ. § 14-404(a)(3)(ii), (19), (22), (40). The charges alleged that Dr. Dadgar violated the standard of care by performing cryosurgery without medical indication, failed to keep adequate medical records, grossly overutilized services by over-performing sonograms and cryosurgery, and that overall, Dr. Dadgar's was guilty of unprofessional conduct in the practice of medicine.

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[1] On September 22, 2020, at the Prehearing Conference before an Administrative Law Judge, the charges were amended without objection. This Order references and considers the amended charges.

On October 6 and 7, 2020, an Administrative Law Judge ("ALJ") held an evidentiary hearing at the Office of Administrative Hearings. On January 5, 2021, the ALJ issued a proposed decision concluding that Dr. Dadgar 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). As a sanction, the ALJ recommended that Dr. Dadgar be reprimanded and placed on probation for one year with conditions including taking courses in recordkeeping and cryosurgery, a prohibition from performing cryosurgery until she completed the coursework, supervision by a Board-approved supervisor for the period of six months following the completion of the cryosurgery course, and payment of a $7,500 fine. The ALJ recommended dismissing the charges of gross overutilization, Health Occ. § 14-404(a)(19) and unprofessional conduct, Health Occ. § 14-404(a)(3)(ii).

On January 19, 2021, Dr. Dadgar filed exceptions to the ALJ's proposed decision. Dr. Dadgar did not take exception to the ALJ's findings of fact or conclusions of law, but requested that the Panel not impose probation and the conditions requiring a supervisor and a course in cryosurgery. The Administrative Prosecutor filed exceptions on behalf of the State, arguing that the ALJ erred in dismissing the charges of gross overutilization of health care services and unprofessional conduct in the practice of medicine. The State also recommended that the probation imposed by the ALJ be increased to 18 months, supervision of cryosurgery for one year, and payment of a $10,000 fine, in addition to the other sanctions recommended by the ALJ. On March 24, 2021, both parties appeared before Disciplinary Panel B of the Board for an exceptions hearing.

FINDINGS OF FACT

Neither the State nor Dr. Dadgar filed exceptions to the factual findings of the ALJ. Because the facts are undisputed, the Stipulated Facts ¶¶ 1-20 and the ALJ's Proposed Findings of

Fact ¶¶ 1-70 are adopted and incorporated by reference into the body of this document as if set forth in full. *See* attached ALJ Proposed Decision, Exhibit 1. The Panel also adopts the ALJ's discussion section in full (pages 17-32). Ex. 1. The findings of fact were proven by the preponderance of the evidence.

ANALYSIS

Failure to meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care - Health Occ. § 14-404(a)(22))

Disciplinary Panel A charged, and the ALJ found, that Dr. Dadgar failed to meet the appropriate standard of care with respect to using cryosurgery as a treatment for cervicitis for two patients, Patient 5 and Patient 6. Neither party objects to this finding and the Board adopts the ALJ's analysis in full. Cervicitis is an inflammation of the uterine cervix and can present as acute or chronic. Acute cervicitis is generally treated with medication because the cause is usually an infection that medication can adequately treat. Chronic cervicitis can be treated by medication but can also be treated with tissue destruction. Cryosurgery or cryotherapy is a relatively safe method of tissue destruction through freezing, commonly done with liquid nitrogen, but it is generally used for pre-cancerous conditions and not cervicitis. The State's expert testified that he was unaware of anyone using cryosurgery in the manner performed by Dr. Dadgar for the past 20 years, while Dr. Dadgar's expert claimed that cryosurgery was performed for cervicitis.

The medical records for Patients 5 and 6 did not indicate whether the patients were being treated for acute or chronic cervicitis, and showed that Dr. Dadgar did not first attempt to try less invasive treatments that could treat both acute and chronic cervicitis prior to resorting to cryosurgery. The Panel finds that Dr. Dadgar's treatment of Patient 5 and 6 with cryosurgery for

cervicitis did not meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care. *See* Health Occ. § 14-404(a)(22).

Failure to keep adequate medical records as determine by appropriate peer review Health Occ. § 14-404(a)(40)

Disciplinary Panel A charged that Dr. Dadgar failed to keep adequate medical records for two patients, Patient 1 and Patient 3. The ALJ found that Dr. Dadgar failed to keep adequate medical records with respect to Patient 1 and Patient 3. Neither party objects to these finding and the Board adopts the finding and analysis in full. For Patient 1, Dr. Dadgar's records stated that the patient had regular menses with heavy blood loss at times, but in Dr. Dadgar's diagnosis she recorded irregular menstruation and cessation of regular menses. Two days after the diagnosis, Dr. Dadgar again diagnosed Patient 1 with frequent and excessive menstruation. The Panel adopts the ALJ's finding that this inconsistent recordkeeping would make it difficult for a reviewing physician to understand and treat Patient 1's condition.

For Patient 3, Dr. Dadgar ordered a sonogram for irregular bleeding, but there was no indication anywhere in the records that Patient 3 complained of irregular bleeding or menses. In sum, Patient 3's records were also contradictory. The Panel finds that these inconsistencies would lead to confusion by a physician reviewing the records. The Panel fully adopts the ALJ's analysis and finds Dr. Dadgar failed to keep adequate medical records as determined by appropriate peer review with regard to Patient 1 and Patient 3. See Health Occ. § 14-404(a)(40).

Grossly Overutilizing Health Care Services – Health Occ. § 14-404(a)(19)

"Overutilization" as commonly understood in the medical profession means unnecessary, or medically unjustified procedures or treatment. "Gross" overutilization goes beyond this however, and means that the unjustified procedures or treatment are obvious and excessive.

Generally, gross overutilization is found where there is a pattern of conduct that is ingrained and systemic.

First, the ALJ found that performing eleven sonograms on Patient 5 over a five year period was not gross overutilization because Patient 5 had multiple conditions that required monitoring. The State's expert described some sonograms as appropriate and some as unusual. The State did not file exceptions on this issue, and the Panel, regardless, agrees with the ALJ's reasoning and finds insufficient evidence to support that the sonograms performed for Patient 5 were a gross overutilization of health care services.

With regard to Dr. Dadgar's performance of cryosurgery, the State argues in its exceptions that Dr. Dadgar should have ruled out more common infectious causes of cervicitis in an attempt to determine whether the cervicitis was acute or chronic before performing the invasive cryosurgery. Dr. Dadgar did not do so here. Next, the State argues that the cryosurgery is a very rare procedure, and that by performing it five times on Patient 5, Dr. Dadgar grossly overutilized medical services. Dr. Dadgar argued that cryotherapy for chronic cervicitis was appropriate.

The Panel finds that Dr. Dadgar's approach to treating cervicitis was flawed. Dr. Dadgar should not have used cryosurgery before determining whether the cervicitis was acute or chronic. It was a violation of the standard of care to treat cervicitis using cryosurgery without trying non-invasive medication options first. Even in cases of chronic cervicitis, the use of cryosurgery has become rare. However, ultimately, the Panel finds that Dr. Dadgar's errors were her failure to diagnose the type of cervicitis and her decision to jump directly to cryosurgery before trying less invasive medication first. These errors in judgment by performing cryosurgery on Patient 5 demonstrate standard of care violations, but do not amount to gross overutilization. Dr. Dadgar's cryosurgeries on Patient 5 did not indicate a systemic pattern or trend of overutilization. While

Dr. Dadgar failed to use the least invasive method available, the treatment was not egregiously excessive and the Panel finds that Dr. Dadgar did not grossly overutilize health care services. The Panel, therefore, denies the State's exception.

Unprofessional Conduct in the Practice of Medicine, Health Occ. § 14-404(a)(3)(ii)

Unprofessional conduct is defined as "conduct which breaches the rules or ethical code of a profession, or which is conduct unbecoming a member of good standing of a profession." *Finucan v. Maryland Board of Physician Quality Assurance*, 380 Md. 577, 594 (2004). Unprofessional conduct may also be found when a physician abuses his or her status as a physician in such a manner as to harm patients or diminish the standing of the medical profession in the eyes of a reasonable member of the general public. *Id.* at 601. The State argues that the cryosurgery procedures discussed in the section regarding standard of care violations were unjustified, invasive, and rare. The State claims that performing this procedure in that manner diminishes the profession in the eyes of the general public. Dr. Dadgar responds that she acted in what she viewed was the best interests of the patient and used her best judgement and did not abuse the status as a physician in such a manner as to harm patients.

The State is correct that the Board has held that standard of care violations can be "so egregious as to amount to unprofessional conduct in themselves." *Geier v. Maryland State Board of Physicians*, 223 Md. App. 404, 415 (2015). In *Geier*, Dr. Geier treated some patients without examining them and reached diagnoses in the absence of required diagnostic tests and found that such conduct was unprofessional in addition to a violation of the standard of care. However, the Panel finds that Dr. Dadgar's performance of cryosurgeries, while violating the standard of care, does not rise to the level of unprofessional conduct and are not akin to treating patients without performing examinations. The Panel denies the State's exception.

CONCLUSIONS OF LAW

Disciplinary Panel B concludes, as a matter of law, that Dr. Dadgar failed to meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care in this state, in violation of Health Occ. § 14-404(a)(22), and failed to keep adequate medical records as determined by appropriate peer review, in violation of Health Occ. § 14-404(a)(40). The Panel dismisses the charges of unprofessional conduct in the practice of medicine, Health Occ. § 14-404(a)(3)(ii), and gross overutilization of health care services, Health Occ. § 14-404(a)(19).

SANCTION

As a sanction, the ALJ recommended that Dr. Dadgar be reprimanded and placed on probation for one year with certain conditions including taking courses in recordkeeping and cryosurgery, be prohibited from performing cryosurgery before completing the coursework, be supervised by a Board-approved supervisor for the period of six months following the completion of the cryosurgery course and pay a $7,500 fine. Dr. Dadgar takes exception to the ALJ's proposed sanction and argues that the probation and the condition of supervision should not be imposed. The State argues that the period of probation and supervision should each be increased by six months and that the fine should be raised to $10,000.

As an initial matter, several mitigating factors are present in this case. Dr. Dadgar has no prior disciplinary history. She exhibits rehabilitative potential, expressing that she has changed her practice to improve her medical recordkeeping process to avoid using templates, took a recordkeeping class, and that she was eager to take another recordkeeping class to continue to improve her recordkeeping practices.

Because Dr. Dadgar has not demonstrated a full understanding of when cryosurgery is appropriate and because she has stated to the Board that she no longer wishes to perform cryosurgery, the Panel will order that Dr. Dadgar be prohibited from performing cryosurgery. Because Dr. Dadgar will not be performing cryosurgery, the Panel finds the recommended course in cryosurgery, supervision, and accompanying probation are unnecessary to protect the public. The Panel will otherwise adopt the ALJ's proposed sanction of a reprimand, $7,500 fine, and coursework in medical recordkeeping.

ORDER

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

ORDERED that Shabnam Dadgar, M.D., is **REPRIMANDED**; it is further

ORDERED that Dr. Dadgar is **PERMANENTLY PROHIBITED** from performing cryosurgery; it is further

ORDERED that on every January 31st thereafter if the Respondent holds a Maryland medical license, the Respondent shall provide the Board with an affidavit verifying that the Respondent has not performed cryosurgery in the past year; and it is further

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

(a) there is a presumption that the Respondent has violated the prohibition on performing cryosurgery; and
(b) the alleged violation will be adjudicated pursuant to the procedures of a Show Cause Hearing; and it is further

ORDERED that within **SIX MONTHS**, Dr. Dadgar shall successfully complete a Panel-approved course in medical recordkeeping. The following terms apply:

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

(b) the disciplinary panel will accept a course taken in-person or over the internet during the state of emergency;
(c) Dr. Dadgar must provide documentation to the disciplinary panel that she has successfully completed the course;
(d) the course may not be used to fulfill the continuing medical education credits required for license renewal;
(e) Dr. Dadgar is responsible for the cost of the course; and it is further

ORDERED that within **TWO YEARS,** the Respondent shall pay a civil fine of **$7,500**. 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 Dr. Dadgar 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. Dadgar allegedly fails to comply with any term or condition imposed by this Final Decision and Order, Dr. Dadgar shall be given notice and an opportunity for a hearing. If Disciplinary Panel B 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. If Disciplinary Panel B determines there is no genuine dispute as to a material fact, Dr. Dadgar shall be given a show cause hearing before Disciplinary Panel B; and it is further

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

ORDERED that the effective date of the Final Decision and Order is the date the Final Decision and Order is signed by the Executive Director of the Board. The Executive Director signs the Final Decision and Order on behalf of Disciplinary Panel B; 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).

06/15/2021
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. Dadgar 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. Dadgar 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 STEPHEN W. THIBODEAU,**
PHYSICIANS	*	**AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE**
SHABNAM DADGAR, M.D.	*	**OF ADMINISTRATIVE HEARINGS**
RESPONDENT	*	
LICENSE No.: D72779	*	**OAH No.: MDH-MBP1-71-20-13948**

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PROPOSED DECISION

STATEMENT OF THE CASE
ISSUES
SUMMARY OF THE EVIDENCE
STIPULATIONS OF FACT
PROPOSED FINDINGS OF FACT
DISCUSSION
PROPOSED CONCLUSIONS OF LAW
PROPOSED DISPOSITION

STATEMENT OF THE CASE

On March 27, 2020, the Maryland State Board of Physicians (Board) issued charges against Shabnam Dadgar, 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 (2014 & Supp. 2019). Specifically, the Respondent is charged with violating section 14-404 of the Act, specifically Health Occ. 14-404(a)(3), unprofessional conduct in the practice of medicine; 14-404(a)(19), gross overutilization of health care services; 14-404(a)(22), failure 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 14-404(a)(40), failure to keep adequate medical records as determined by appropriate peer review. (Supp. 2019); Code of Maryland Regulations (COMAR) 10.32.02.03E(3)(d). The Board notified the Respondent that if, after a hearing, a disciplinary

panel of the Board finds that there are grounds for action under the aforementioned sections of the Health Occupations Article, the Board may impose disciplinary sanctions against the Respondent's license, including revocation, suspension, reprimand and/or probation. The Board further advised the Respondent that, in addition to one or more of those sanctions, the disciplinary panel may impose a civil monetary fine upon the Respondent.

The disciplinary panel to which the complaint was assigned held a meeting with the Respondent on June 10, 2020 to explore the possibility of resolution. COMAR 10.32.02.03E(9). The parties did not resolve the issues at that time. The disciplinary panel to which the complaint was assigned forwarded the charges to the Office of the Attorney General for prosecution, and another disciplinary panel delegated the matter to the Office of Administrative Hearings (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).

Following a telephone scheduling conference held on July 22, 2020, and a subsequent telephone prehearing conference held on September 22, 2020, I held a hearing on October 6 and 7, 2020, via the WebEx videoconferencing platform. Health Occ. § 14-405(a) (Supp. 2020); COMAR 10.32.02.04; COMAR 28.02.01.20B. Robert Maynard, Esquire, represented the Respondent, who was present. Katherine Vehar-Kenyon, Assistant Attorney General, Health Occupations Prosecution & Litigation Division, represented the Board.

Procedure in this case 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 (2014 & Supp. 2020); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

1. Did the Respondent violate the cited provisions of the applicable law? If so,

2. What sanctions are appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following exhibits into evidence on behalf of the Board:

Bd. Ex. 1 - March 3, 2018 Complaint against the Respondent (pp. SD0001-SD0011)[1]
Bd. Ex. 2 - October 3, 2018 Complaint against the Respondent (pp. SD0012-SD0017)
Bd. Ex. 3 - February 22, 2019 Complaint against the Respondent (pp. SD0018-SD0023)
Bd. Ex. 4 - Respondent's November 6, 2018 Response to the Board to the March 3, 2018 Complaint (pp. SD0024-SD0036)
Bd. Ex. 5 - Respondent's November 6, 2018 Response to the Board to the October 3, 2018 Complaint (pp. SD0037-SD0039)
Bd. Ex. 6 - Respondent's March 28, 2019 Response to the Board to the February 22, 2019 Complaint (pp. SD0455-SD0456)
Bd. Ex. 7 - April 26, 2019 Subpoena mailed to the [redacted]
Bd. Ex. 8 - [redacted] Quality Assurance/Risk Management File, undated (pp. SD0042-SD0044)
Bd. Ex. 9 - Transcript of Respondent's April 8, 2019 Interview with the Board (pp. SD0056-SD0070)
Bd. Ex. 10 - Documents provided by the Respondent at the Interview (pp. SD0071-SD0083)
Bd. Ex. 11 - Three Board subpoenas for Patient records dated April 10, 2018, October 23, 2018, and March 13, 2019
Bd. Ex. 12 - Respondent's Summary of Care for [redacted][2] (Patient 1) (pg. SD0345)
Bd. Ex. 13 - Medical Record Certification for Patient 1, November 30, 2018 (pg. SD0346)
Bd. Ex. 14 - Medical Records for Patient 1 (pp. SD0347-SD0371)
Bd. Ex. 15 - Respondent's Summary of Care for [redacted] (Patient 2) (pp. SD0373-SD0376)
Bd. Ex. 16 - Medical Record Certification for Patient 2 (pg. SD0377)
Bd. Ex. 17 - Medical Records for Patient 2 (pp. SD0378-SD0450)
Bd. Ex. 18 - Board Subpoena for Patient 2 and [redacted] (Patient 5) Billing Records, January 17, 2019
Bd. Ex. 19 - Patient 2 Billing Records (pp. SD0451-SD0454)
Bd. Ex. 20 - Respondent's Summary of Care for [redacted] (Patient 3) (pp. SD0040-SD0041)
Bd. Ex. 21 - Medical Records for Patient 3 (pp. SD0457-SD0494)
Bd. Ex. 22 - Respondent's Summary of Care for Patient 5 (pp. SD0522-SD0527)
Bd. Ex. 23 - Medical Record Certification for Patient 5 (pg. SD0528)
Bd. Ex. 24 - Medical Records for Patient 5 (pp. SD0529-SD0764)
Bd. Ex. 25 - Patient 5 Billing Records (pp. SD0765-SD0768)
Bd. Ex. 26 - Respondent's Summary of Care for [redacted] (Patient 6) (SD0769-SD0771)

[1] Bates stamp page numbers for the Board's exhibits are provided unless the exhibit did not include page numbers.
[2] For each patient, I have used the patient's initials to preserve the confidentiality of the patients.

Bd. Ex. 27 - Medical Record Certification for Patient 6 (pg. SD0772)
Bd. Ex. 28 - Medical Records for Patient 6 (pp. SD0773-SD0834)
Bd. Ex. 29 - Patient 6 Billing Records (pp. SD0835-SD036); Board Subpoena for Patient 6 Billing Records, January 25, 2019
Bd. Ex. 30 - Curriculum Vitae for Dr. [redacted]
Bd. Ex. 31 - Dr. [redacted]'s Peer Review for the Respondent pursuant to Md. Code Ann., Health Occ. § 14-404(a)(22) and (40), July 23, 2019
Bd. Ex. 32 - Dr. [redacted]'s Peer Review for the Respondent pursuant to Md. Code Ann., Health Occ. § 14-404(a)(19), July 23, 2019
Bd. Ex. 33 - "Treatment of chronic cervicitis by cryotherapy" by Dr. Donald R. Ostergard, Dr. Duane E. Townsend, and Dr. Frank M. Hirose, American Journal of Obstetrics and Gynecology, pp. 426-432, October 1, 1968
Bd. Ex. 34 - "Treatment of cervical intraepithelial lesions" by Dr. Philip E. Castle, Dr. Dan Murokora, Dr. Carlos Perez, Dr. Manuel Alvarez, Dr. Swee Chong Quek, and Dr. Christine Campbell, International Journal of Gynecology & Obstetrics, pp. 20-25, 2017
Bd. Ex. 35 - Respondent's Supplemental Response to the Peer Review Reports, September 25, 2019
Bd. Ex. 36 - Charges against the Respondent by the Board under the Maryland Medical Practice Act, March 27, 2020

I admitted the following exhibits into evidence on behalf of the Respondent:

Resp. Ex. 1 - Curriculum Vitae for the Respondent (pp. 001-006)
Resp. Ex. 2 - Curriculum Vitae for Dr. [redacted] (pp. 007-031)
Resp. Ex. 3 - Report of Dr. [redacted] (pp. 032-042)
Resp. Ex. 4 - Reference List for Dr. [redacted]'s report (pg. 043)
Resp. Ex. 5 - "Cryosurgery for Benign Cervical Lesions" by J.E. Peck, British Medical Journal, pp. 198-199, 1974 (pp. 044-045)
Resp. Ex. 6 - "Cervical Cryotherapy for Condylomata Acuminata During Pregnancy" by Dr. Arieh Bergman, Dr. Jon Matsunaga, and Dr. Narender N. Bhatia, Obstetrics and Gynecology, pp. 47-50, January 1987 (pp. 046-049)
Resp. Ex. 7 - "Treatment of Cervical Precancers" by Dr. Michelle J. Khan and Dr. Karen K. Smith-McCune, Obstetrics and Gynecology, pp. 1339-1343, June 2014 (pp. 050-054)
Resp. Ex. 8 - "Surgery for Cervical Intraepithelial Neoplasia (CIN)" by Pierre PL Martin-Hirsch, Evangelos Paraskevaidis, Andrew Bryant, Heather O. Dickison, and Sarah L. Keep, Cochrane Database Syst. Rev., December 4, 2013 (pp. 055-196)
Resp. Ex. 9 - "Screening for Cervical Cancer," U.S. Preventative Services Task Force Recommendation Statement, 2018 (pp. 197-209)
Resp. Ex. 10 - "Treatment of chronic cervicitis by cryotherapy" by Dr. Donald R. Ostergard, Dr. Duane E. Townsend, and Dr. Frank M. Hirose, American Journal of Obstetrics and Gynecology, pp. 426-432, October 1, 1968 (pp. 210-216)
Resp. Ex. 11 - "Treatment of cervical intraepithelial lesions" by Dr. Philip E. Castle, Dr. Dan Murokora, Dr. Carlos Perez, Dr. Manuel Alvarez, Dr. Swee Chong Quek, and Dr. Christine Campbell, International Journal of Gynecology & Obstetrics, pp. 20-25, 2017 (pp. 217-222)

Resp. Ex. 12 - Online research by Dr. [redacted], including article from Penn State University Milton S. Hershey Medical Center ("Cervix Cryosurgery") (pp. 223-224) and Planned Parenthood ("What is cryotherapy?") (pp. 225-228)

Resp. Ex. 13 - "Cryosurgery of the Cervix: Procedure Details" from the Cleveland Clinic (pp. 229-231)

Resp. Ex. 14 - "Cervical Intraepithelial Neoplasia: Ablative Therapies", reprinted from UpToDate, June 11, 2020 (pp. 233-244)

Resp. Ex. 15 - Mayo Clinic Diagnosis and Treatment of HPV Infection (pp. 245-247)

Resp. Ex. 16 - American College of Obstetricians and Gynecologists (ACOG) Committee Opinion on Cervical Cancer Screening in Low-Resource Settings, February 2015 (pp. 248-250)

Resp. Ex. 17 - "What is Cryotherapy?", reprinted from WebMD website (pp. 251-254)

Resp. Ex. 18 - "Cost and Cost-Effectiveness of LEEP versus Cryotherapy for Treating Cervical Dysplasia Among HIV Positive Women in Johannesburg, South Africa" by Naomi Lince-Deroche, Craig van Rensburg, Jaqueline Roseleur, Busola Sanusi, Jane Phiri, Pam Michelow, Jennifer S. Smith and Cindy Firnhaber, reprinted in PLOS One, October 11, 2018 (pp. 255-267)

Resp. Ex. 19 - "LEEP Verses Cryotherapy in CIN" by Singh Abha, Arthur Bhavna, and Agarwal Vivek, The Journal of Obstetrics and Gynecology of India, July-August 2011 (pp. 268-272)

Resp. Ex. 20 - Article from the United Kingdom's National Health Service website, "Treatment if you have abnormal cervical cells" (pp. 273-278)

Resp. Ex. 21 - World Health Organization Guidelines for the Use of Cryotherapy for CIN (pp. 279-302)

Resp. Ex. 22 - "Effectiveness, safety and acceptability of 'see and treat' with cryotherapy by nurses in a cervical screening study in India," British Journal of Cancer, February 20, 2007 (pp. 303-309)

Resp. Ex. 23 - "Cervical intraepithelial neoplasia: Choosing excision versus ablation, and prognosis and follow-up after treatment" by Dr. Jason D. Wright, reprinted in UpToDate, August 28, 2020 (pp. 310-328)

Resp. Ex. 24 - "Cryotherapy as a Method for Relieving Symptoms of Cervical Ectopy: A Randomized Clinical Trial," by Jila Agah, Masoumeh Sharifzadeh, and Ali Hosseinzadeh, Oman Medical Journal, January 27, 2019 (pp. 329-333)

Resp. Ex. 25 - "The importance of cryosurgery in gynecological practice," by Rokita Wojciech, Ginekolog Polska, July 20, 2011 (pp. 334-338)

Resp. Ex. 26 - "Is Cryotherapy Friend or Foe for Symptomatic Cervical Ectopy?", by Tasemin Cekmez, Fatih Sanlikan, Ahmet Gocmen, Aylin Vural, and Simge Bagci Turkmen, reprinted from Karger Open Access, October 27, 2015 (pp. 339-342)

Resp. Ex. 27 - "Acute cervicitis," reprinted from UpToDate (pp. 343-364)

Resp. Ex. 28 - "Treatment of Chronic Cervicitis by Cryotherapy," Miyoji Kuribayashi, Michiro Maekawa, and Saburo Okabe, Japanese Journal of National Medical Services, 1974 (pp. 365-366)

Resp. Ex. 29 - "Cryosurgery for benign cervicitis with follow-up of six and half years," by Dr. Robert J. Collins and Dr. Harry J. Pappas, American Journal of Obstetrics and Gynecology, July 15, 1972 (pp. 367-369)

Resp. Ex. 30 - Printout of the National Health Service of the United Kingdom regarding colposcopy treatments (pp. 370-375)

Resp. Ex. 31 - Abstract of "Fertility after cryosurgery of the cervix" article, August 1978 (pg. 376)

Testimony

The following witness testified on behalf of the Board: Dr. [redacted], who I accepted as an expert in the overall medical specialty of obstetrics and gynecology, the appropriate use criteria for pelvic sonograms, the diagnosis and treatment of cervicitis, the application of the appropriate use criteria for cryosurgery/cryotherapy, and standards of appropriate and complete medication documentation.

The Respondent testified in her own behalf, and presented the following witness: Dr. [redacted], who I accepted as an expert in the overall medical specialty of obstetrics and gynecology, the appropriate use criteria for pelvic sonograms, the diagnosis and treatment of cervicitis, the application of the appropriate use criteria for cryosurgery/cryotherapy, and standards of appropriate and complete medication documentation.

STIPULATIONS OF FACT

The parties stipulated to the following facts:

1. At all relevant times, the Respondent was licensed to practice medicine in the State of Maryland. The Board initially issued the Respondent a license to practice medicine in Maryland on July 19, 2011, under License Number D72779. Her license is active through September 30, 2020. She is also licensed in Virginia and Washington, D.C.

2. The Respondent is board certified in obstetrics and gynecology.

3. The Respondent practices at a health care facility in Rockville, Maryland and has privileges at two Maryland hospitals.

4. On March 5, 2018, the Board received a complaint (Complaint 1) from a former patient of the Respondent alleging that the Respondent unnecessarily referred her for cryosurgery.

5. Cryosurgery is a surgery where diseased or abnormal tissue is destroyed or removed by freezing.

6. The Board initiated an investigation into Complaint 1 and assigned this matter Case Number 2219-008 A.

7. As part of its investigation, the Board obtained a series of records pertaining to Complaint 1, notified the Respondent about the investigation, provided the Respondent a copy of Complaint 1, and requested a written response.

8. While the Board was investigating Case Number 2219-0008 A, the Board received a second complaint (Complaint 2) regarding the Respondent on October 9, 2018. Complaint 2 was from a former patient of the Respondent alleging that the Respondent gave her incorrect, incomplete information regarding her diagnosis and treatment and unnecessarily recommended medical tests.

9. The Board opened a second case in response to Complaint 2 and assigned it Case Number 2219-00067 A. The Board also notified the Respondent about Complaint 2, provided the Respondent a copy of Complaint 2, and requested a written response.

10. As part of its investigation of the Respondent, the Board subpoenaed a series of patient records.

11. On February 28, 2019, the Board received a third complaint (Complaint 3) from a former patient of the Respondent alleging that the Respondent gave false diagnoses and performed unnecessary painful treatments and procedures.

12. The Board notified the Respondent regarding Complaint 3, provided the Respondent a copy of Complaint 3, and requested a written response.

13. The Board incorporated its investigation of Complaint 3 into Case Number 2219-0067 A and subpoenaed additional medical records pertaining to Complaint 3.

14. As part of its investigation of the Respondent in Case Numbers 2219-0008 A and 2219-0067 A, the Board obtained records regarding seven patients from the Respondent.

15. The records transmitted to the Board by the Respondent in response to the Board's subpoena are authentic.

16. The Respondent provided written responses to the three complaints that were received by the Board on November 6, 2018 and March 28, 2019.

17. The Board interviewed the Respondent on April 8, 2019 during which time the Respondent provided documents to the Board.

18. The Board referred the investigatory file to a peer review entity.

19. The Board provided the Respondent the peer review findings.

20. The Respondent responded to the peer review filings by letter dated September 25, 2019.

PROPOSED FINDINGS OF FACT

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

General Information on the Patients Treated by the Respondent

1. The Respondent practices primarily in the field of gynecology. As such, all the patients noted in the following finding of facts are female.

2. Patient 1 was 51 years old at the time she received gynecological treatment from the Respondent on the following dates: September 17, 2018 and September 19, 2018.

3. Patient 2 was 20 years old when she first saw the Respondent for gynecological treatment. Patient 2 had multiple officc visits with the Respondent on the following dates: April 10, 2017; April 17, 2017; April 25, 2017; June 6, 2017; June 13, 2017; July 5, 2017; September 11, 2017; September 14, 2017; October 10, 2017; April 4, 2018; April 6, 2018; April 11, 2018; May 7, 2018; October 9, 2018; October 15, 2018; and November 5, 2018.

4. Patient 3 was 34 years old when she first saw the Respondent for gynecological treatment. Patient 3 had multiple office visits with the Respondent on the following dates: August 16, 2018; August 31, 2018; September 10, 2018; September 18, 2018; September 27, 2018; October 29, 2018; and November 2, 2018.

5. Patient 5 was 14 years old when she first saw the Respondent for gynecological treatment. Patient 5 had multiple office visits with the Respondent on the following dates: August 21, 2013; August 22, 2013; September 13, 2013; April 18, 2014; April 24, 2014; May 1, 2014; May 15, 2014; June 13, 2014; August 22, 2014; September 11, 2014; October 10, 2014; January 14, 2015; April 27, 2015; June 3, 2015; December 24, 2015; January 22, 2016; February 11, 2016; March 28, 2016; September 26, 2016; October 17, 2016; July 17, 2017; July 20, 2017; July 24, 2017; July 28, 2017; August 10, 2017; September 5, 2017; September 19, 2017; September 19, 2017; October 6, 2017; October 17, 2017; October 23, 2017; October 25, 2017; October 27, 2017; November 2, 2017; November 21, 2017; December 20, 2017; January 5, 2018; May 9, 2018; June 8, 2018; June 11, 2018; June 22, 2018; June 25, 2018; June 27, 2018; July 2, 2018; July 19, 2018; August 2, 2018; August 24, 2018; and September 4, 2018.

6. Patient 6 was 20 years old when she first saw the Respondent for gynecological treatment. Patient 6 had multiple office visits with the Respondent on the following dates: January 19, 2016; February 2, 2016; February 19, 2016; June 20, 2018; June 25, 2018; July 2,

2018; July 11, 2018; August 1, 2018; August 24, 2018; August 29, 2018; September 12, 2018; and September 19, 2018.

Medical Records and Documentation

7. The purpose of medical documentation for a physician's patient is to provide a history of diagnoses, conditions, status of conditions, and prior treatments.

8. Adequate medical documentation should provide enough information to another physician in case another physician should need to step in and assume a patient's care. This is commonly known as "continuity of care."

9. Medical records typically provide objective and subjective components.

10. Objective findings are those that are measurable by the physician at the time of a patient visit. They may include recorded vital signs such as a patient's temperature, blood pressure, and weight, as well as findings made by the physician at the time of the patient's exam, including test results.

11. Subjective findings typically include descriptions by the patient of her symptoms, as well as subjective observations by the physician of the patient at the time of exam, such as observations relating to the patient's appearance.

12. Medical records for a typical gynecological exam will include the components generally found in all medical records. Such records will provide historical information for the patient, such as any past surgical, obstetrical gynecological, family, and social history. The records will also provide a review of systems giving general information regarding the patient's various body systems, such as respiratory, cardiovascular, neurological, psychiatric, and reproductive systems.

Patient 1's Medical Records

13. Pursuant to subpoena, the Board obtained medical records for Patient 1's treatment on September 17, 2018 and September 19, 2018.

14. On September 17, 2018, Patient 1 visited the Respondent for her annual gynecological exam. Patient 1 indicated that she was experiencing hot flashes and was recently referred for a follow-up examination with a gynecologist due to a recent magnetic resonance imaging scan showing a cyst on the patient's right side. (Bd. Ex. 14, SD0347).

15. As part of her gynecological history, Patient 1 reported having regular menses with heavy blood loss at times. (Bd. Ex. 14, SD0347).

16. According to the review of systems for Patient 1 from her September 17, 2018 visit, however, Patient 1 denied having any of the following conditions related to her gynecological condition, in contradiction of her stated reason for her exam: heavy bleeding during menses, hot flashes, irregular menses, missed periods, painful intercourse, painful menses, vaginal bleeding between periods, vaginal discharge and itching. (Bd. Ex. 14, pg. SD0348).

17. On examination of Patient 1, the Respondent noted discharge present upon examination of her vaginal vault. (Bd. Ex. 14, pg. SD0349).

18. The Respondent diagnosed Patient 1 with several conditions, including acute vaginitis (inflammation of the vagina); acute vulvitis (inflammation of the vulva); irregular menstruation, unspecified; and secondary amenorrhea (cessation of regular menses). (Bd. Ex. 14, pg. SD0349).

19. The diagnosis regarding irregular menstruation and secondary amenorrhea contradict the review of systems for Patient 1 where she denies such conditions.

20. The Respondent noted in Patient's 1 record, as part of her treatment notes, that Patient 1 "started to miss some of her menses" and the Respondent advised Patient 1 to get follow-up blood work and a sonogram. (Bd. Ex. 14, pg. SD0349).

21. Sonograms are images produced using ultrasound technology, which uses high frequency sound waves to produce images of structures inside the human body.

22. Patient 1 followed up with the Respondent for a sonogram on September 19, 2018. The records for that visit indicate no change for Patient 1's review of systems on her September 17, 2018 record. However, the Respondent now diagnosed Patient 1 with pelvic and perineal pain and excessive and frequent menstruation with regular cycle. (Bd. Ex. 14, pg. SD0353).

23. No other diagnoses were noted by the Respondent on Patient 1's September 19, 2018 medical record.

Patient 3's Medical Records

24. The Board obtained several medical records for Patient 3 from the Respondent from August to November 2018.

25. Patient 3's August 21, 2018 medical record indicated she visited the Respondent to obtain a sonogram for irregular bleeding. (Bd. Ex. 21, pg. SD0461).

26. During the August 21, 2018 visit, Patient 3 denied irregular bleeding as part of a review of her systems. (Bd. Ex. 21, pg. SD0462).

27. On August 21, 2018, the Respondent did not diagnosis Patient 3 with irregular bleeding. (Bd. Ex. 21, pp. SD0462-SD0463).

28. Likewise, in an office visit just five days before, Patient 3 did not report irregular bleeding as part of review of systems, and the Respondent did not provide a diagnosis of irregular menses. (Bd. Ex. 21, pp. SD0458-SD0460).

Use of Sonograms in Gynecology

29. Sonograms are generally accepted in gynecological medical practice to diagnose and monitor conditions related to the female reproductive system.

30. Pelvic sonograms, in relation to gynecology, can be ordered for a variety of reasons, including: evaluation of pelvic pain or masses; evaluation of endocrine abnormalities, including polycystic ovaries; and evaluation of painful, missed, irregular, delayed, or abnormal menses. (Bd. Ex. 4, SD0029).

31. The conditions that may justify a pelvic sonogram do not necessarily require a sonogram be ordered. Depending on the condition, these conditions can often be diagnosed, monitored, and evaluated without a sonogram.

Patient 2's Sonograms

32. Patient 2 received annual gynecological care from the Respondent, as well as treatment for vaginitis, contraception, polycystic ovarian syndrome (PCOS), and menstruation issues.

33. Sonograms were performed on Patient 2 on April 17, 2017; June 6, 2017; September 14, 2017; and April 6, 2018.

34. On Patient 2's April 17, 2017 medical record, the reason for her appointment is a "sono for intermenstrual," indicating that the sonogram was order to diagnosis Patient 2's bleeding outside of her regular menses. (Bd. Ex. 17, pg. SD0431).

35. The sonogram performed on Patient 2 on April 17, 2017 discovered a cyst on her right side and recommended a follow-up sonogram in six weeks. (Bd. Ex. 17, SD0446).

36. Patient 2 followed up approximately six weeks later for another sonogram on June 6, 2017. The stated reason on Patient 2's medical record was a "sono for irregular bleeding." (Bd. Ex. 17, SD0425).

37. Patient 2's sonogram record for June 6, 2017, however, indicated the discovery of polycystic ovaries bilaterally. (Bd. Ex. 17, SD 0448).

38. Patient 2 returned for a follow-up sonogram with the Respondent on September 14, 2017, for a "missed period and PCO" (polycystic ovary syndrome). (Bd. Ex. 17, SD0409).

39. Finally, Patient 2 had another sonogram on April 6, 2018 for a "heavy and irregular period." (Bd. Ex. 17, SD0395).

40. The findings on Patient 2's sonogram record for April 6, 2018 was for a polycystic ovary on the left. (Bd. Ex. 17, SD0450).

Patient 5's Sonograms

41. Patient 5 received general gynecological care from the Respondent beginning at age 14 in 2013, and was treated for painful periods, irregular menses, cramps, and vaginitis.

42. Sonograms were performed on Patient 5 on the following dates: August 22, 2013; April 24, 2014; October 10, 2014; June 3, 2015; October 17, 2016; July 20, 2017; November 21, 2017; May 9, 2018; June 11, 2018; June 25, 2018; and July 2, 2018.

43. The following indications were provided in Patient 5's medical records for each of the sonograms as follows:

- August 22, 2013: Pain and irregular and heavy periods (Bd. Ex. 24, SD0733)
- April 24, 2014: Excessive or frequent menstruation and irregular menstrual cycle (Bd. Ex. 24, SD0723)
- October 10, 2014: Abnormal uterine bleeding and PCOS (Bd. Ex. 24, SD0694, SD0696)
- June 3, 2015: Bleeding, excessive or frequent menstruation and irregular menstrual cycle (Bd. Ex. 24, SD0684, SD0686)
- October 17, 2016: Cramps (Bd. Ex. 24, SD0661)
- July 20, 2017: Heavy period, PCOS work up and counseling (Bd. Ex. 24, SD0651)
- November 21, 2017: Cyst follow up and pain (Bd. Ex. 24, SD0593)
- May 9, 2018: Cyst (Bd. Ex. 24, SD0565)
- June 11, 2018: Irregular menstruation and positive pregnancy test (Bd. Ex. 24, SD0559)

- June 24, 2018: Cramps and bleeding following termination (of pregnancy) with medication (Bd. Ex. 24, SD0553)
- July 2, 2018: Follow up for bleeding and possible passing of tissue (Bd. Ex. 24, SD0546)

44. The results for each of Patient 5's sonograms are noted by the Respondent in Patient 5's medical records as follows:

- August 22, 2013: Normal pelvic ultrasound (Bd. Ex. 24, SD0737)
- April 24, 2014: Possible polycystic ovaries bilaterally (Bd. Ex. 24, SD0723)
- October 10, 2014: Polycystic ovaries on right side (Bd. Ex. 24, SD0696)
- June 3, 2015: Normal sonogram (Bd. Ex. 24, SD0684, SD0686)
- October 17, 2016: Normal sonogram (Bd. Ex. 24, SD0663)
- July 20, 2017: Polycystic ovaries on right side (Bd. Ex. 24, SD0654)
- November 21, 2017: Normal sonogram (Bd. Ex. 24, SD0596)
- May 9, 2018: Normal sonogram (Bd. Ex. 24, SD0573)
- June 11, 2018: Pregnancy detected (Bd. Ex. 24, SD0560)
- June 24, 2018: Incomplete termination of pregnancy, possible product of conception detected (Bd. Ex. 24, SD0554, SD0755)
- July 2, 2018: Retained portions of placenta and membranes, without hemorrhage (Bd. Ex. 24, SD0547)

Cervicitis and Cryosurgery

45. Cervicitis is an inflammation of the uterine cervix.

46. Symptoms of cervicitis include pain, vaginal discharge, and abnormal bleeding between regular menses.

47. There are two forms of cervicitis: acute and chronic.

48. Acute cervicitis is a form of cervicitis that has a sudden onset and is almost always caused by infectious bacteria, often as a result of a sexually transmitted infection.

49. Acute cervicitis is typically treated with medication. The medication prescribed would depend on the type of infection and could include antibiotic or antiviral medication.

50. Chronic cervicitis may be caused by infectious bacteria, but also may be as a result of outside irritants or allergic reactions.

51. The treatment regimen for chronic cervicitis is similar to acute cervicitis. Depending on the diagnosed cause of the chronic cervicitis, the appropriate medications are prescribed. However, if medications do not resolve the chronic cervicitis, various methods of tissue destruction may be used to resolve the inflammation.

52. Common methods of tissue destruction used for treatment of chronic cervicitis include chemical cautery or a loop electrosurgical excision procedure.

53. Cryosurgery (also known as cryotherapy) is another method of tissue destruction that freezes tissue, typically by the local application of liquid nitrogen on the tissue.

54. Cryosurgery is generally used to remove pre-cancerous cells from the cervix.

55. Since 1968, cryosurgery has been an accepted form of treatment for chronic cervicitis. (Bd. Ex. 33; Resp. Ex. 10). However, in the last twenty years, use of cryosurgery to treat chronic cervicitis has become rare.

56. One potential side effect of cryosurgery on the cervix is cervical stenosis (scarring of the cervix).

Patient 5's Cryotherapy Treatment for Cervicitis

57. Patient 5 received cryotherapy for cervicitis on five occasions: February 11, 2016; March 28; 2016; August 10, 2017; September 5, 2017; and October 6, 2017.

58. At no time during the Respondent's treatment of Patient 5 was there any indication of pre-cancerous cells present on Patient 5's cervix.

59. The Respondent's treatment of Patient 5 on February 11, 2016, per the medical records, indicates that Patient 5 received cryotherapy for cervicitis; however, there was no indication whether Patient 5's cervicitis was acute or chronic. (Bd. Ex. 24, SD0671-SD0673).

60. Per the February 11, 2016 medical record, there was no indication that tests were performed on Patient 5 to determine the cause of the cervicitis.

61. Three weeks prior, on January 22, 2016, Patient 5 received treatment for vaginitis and was prescribed a topical gel for that condition. (Bd. Ex. 24, SD0673-SD0678).

62. Patient 5's next visit to the Respondent occurred on March 28, 2016. Again, Patient 5 received cryotherapy for cervicitis, and again there was no indication whether Patient 5's cervicitis was acute or chronic, and no indication that tests were performed to determine the potential cause of the cervicitis. (Bd. Ex. 24, SD0668-SD0670).

63. Similarly, on August 10, 2017, the Respondent treated Patient 5 for cervicitis with cryotherapy, and again there was no indication whether Patient 5's cervicitis was acute or chronic, and no indication thar tests were performed to determine the potential cause of the cervicitis. (Bd. Ex. 24, SD0637-SD0640).

64. This pattern occurred again approximately a month later at Patient 5's next visit with the Respondent, on September 5, 2017, when another cryotherapy for cervicitis was performed. Again, there was no indication whether Patient 5's cervicitis was acute or chronic, and no indication that tests were performed to determine the potential cause of the cervicitis. However, at this visit, Patient 5 was diagnosed with acute vaginitis. (Bd. Ex. 24, SD0633-SD0636).

65. The final cryosurgery performed on Patient 5 by the Respondent occurred on October 6, 2017. The medical records indicate a similar course of care to Patient 5's September 5, 2017 visit, with no further information provided to Patient 5's cervicitis, no testing performed relative to Patient 5's cervicitis, and a diagnosis of acute vaginitis. (Bd. Ex. 24, SD0617-SD0619).

<u>Patient 6's Cryotherapy for Cervicitis</u>

66. Patient 6 saw the Respondent for general gynecological care for vaginitis, pain with menses, irregular menses, and cervicitis.

67. On September 19, 2018, Patient 6 sought treatment from the Respondent for acute vaginitis, unprotected intercourse, and cryotherapy for cervicitis. (Bd. Ex. 28, SD0773-SD0775). Cryotherapy was performed for Patient 6's cervicitis.

68. There was no indication in the September 19, 2018 medical record that Patient 6's cervicitis was acute or chronic, and no tests were performed to determine the potential cause of the cervicitis. A topical gel was prescribed for the acute vaginitis.

69. Patient 6 was diagnosed with chlamydia on July 2, 2018 and was prescribed antibiotics to treat the chlamydia at that time. Patient 6 had completed her antibiotics course by the time of her September 19, 2018 cryotherapy treatment.

Other Factors

70. The Respondent has no prior disciplinary history with the Board.

DISCUSSION

When not otherwise provided by statute or regulation, the standard of proof in a contested case hearing before the OAH is a preponderance of the evidence, and the burden of proof rests on the party making an assertion or a claim. Md. Code Ann., State Gov't § 10-217 (2014); COMAR 28.02.01.21K. To prove an assertion or a claim by a preponderance of the evidence means to show that it is "more likely so than not so" when all the evidence is considered. *Coleman v. Anne Arundel Cty. Police Dep't*, 369 Md. 108, 125 n.16 (2002). In this case, the Board bears the burden to prove the alleged charges by a preponderance of the evidence. COMAR 28.02.01.21K(1)-(2)(a).

I. The Charges

The grounds for reprimand or probation of a licensee, or suspension or revocation of a license under the Act include the following:

> (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:
>
> (i) Immoral conduct in the practice of medicine; or
>
> (ii) Unprofessional conduct in the practice of medicine;
>
> . . .
>
> (19) Grossly overutilizes health care services;
>
> . . .
>
> (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[.]
>
> . . .

Health Occ. § 14-404(a)(3), (19), (22), (40) (Supp. 2020).

Here, the Board charged the Respondent with violations of the provisions of section 14-404(a) of the Health Occupations Article regarding Patients 1, 2, 3, 5 and 6 in relevant part, as follows:

- The Respondent failed to meet appropriate standards of the delivery of quality medical care, specifically in performing cryosurgery for the treatment of cervicitis as to Patients 5 and 6;
- The Respondent failed to keep adequate medical records, specifically failing to document patient symptoms as the basis of ordering medical imaging tests as to Patients 1 and 3;
- The Respondent grossly overutilized health care services, specifically gross overutilization of pelvic sonograms as to Patients 2 and 5, and unnecessary cryosurgery procedures as to Patients 5 and 6; and
- The Respondent's actions in all these areas constituted unprofessional conduct in the practice of medicine.

II. Arguments of the Parties

The Board argued that based upon the peer review of the Respondent's medical records, the Respondent failed to meet the standard of care for quality medical care for Patients 5 and 6 by performing cryosurgery to treat cervicitis when cryosurgery is not widely accepted for the treatment of cervicitis. In particular, the Board maintained that the Respondent did not distinguish the type of cervicitis (either acute or chronic) present in Patients 5 and 6, and failed to

determine whether the cervicitis could be treated with a less invasive treatment, which constituted a failure to meet the standard of care for quality medical care.

The Board further argued that the Respondent failed to keep adequate medical records as to Patients 1 and 3, in that in multiple instances the symptoms justifying a diagnosis were contradicted within the records themselves. As such, the records shifted the burden to a reviewing physician to speculate as to the proper course of treatment for Patients 1 and 3, thus disrupting the continuity of care for each patient.

The Board also argued that the Respondent's order for sonograms for Patients 2 and 5, and cryosurgeries for Patients 5 and 6, constituted gross overutilization of health care services. In each instance, the Board argued, the Respondent did not provide adequate justification for the utilization of health care services over the period of time for each patient, without concern for the costs of the treatment, which resulted in gross overutilization of health care services.

Finally, the Board argued that taken as a whole, the Respondent's conduct with respect to all these patients constituted unprofessional conduct in the practice of medicine. Specifically, the Respondent's conduct cumulatively had the effect of members of the public questioning her conduct as a physician.

The Respondent argued the Board failed to meet its burden of proof as to the charges, and contended the Respondent's medical recordkeeping was enough to provide a complete picture for each patient to allow for a reviewing physician to provide continuity of care; that cryotherapy is an accepted treatment for chronic cervicitis and therefore the Respondent did not violate the standard of care for quality medical care; the sonograms ordered and cryotherapies performed did not constitute gross overutilization of medical care services because the treatments were indicated for the diagnosis for each patient; and overall, the Respondent acted professionally in her practice of medicine and did not harm any of the patients presented in the Board's case.

III. Expert Witnesses

The Board called one of the peer reviewers, Dr. [redacted], who is board certified in obstetrics and gynecology, and offered him as an expert in in the overall medical specialty of obstetrics and gynecology, the appropriate use criteria for pelvic sonograms, the diagnosis and treatment of cervicitis, the application of the appropriate use criteria for cryosurgery/cryotherapy, and standards of appropriate and complete medication documentation. The Respondent called Dr. [redacted], who is also board certified in obstetrics and gynecology, and offered him as an expert in the same areas as Dr. [redacted].

On the issue of expert testimony, the Court of Appeals has held: "The premises of fact must disclose that the expert is sufficiently familiar with the subject matter under investigation to elevate his opinion above the realm of conjecture and speculation, for no matter how highly qualified the expert may be in his field, his opinion has no probative force unless a sufficient factual basis to support a rational conclusion is shown." *Bohnert v. State*, 312 Md. 266, 274 (1988) (social worker's expert testimony that child under age of fourteen was a victim of sexual abuse was inadequately supported and was inadmissible in prosecution for second-degree sexual offense) citing *State, Use of Stickley v. Critzer*, 230 Md. 286, 290 (1962). The Maryland Rules provide: "Expert testimony may be admitted . . . if the court determines that the testimony will assist the trier of fact to . . . determine a fact in issue. In making that determination, the court shall determine . . . whether a sufficient factual basis exists to support the expert testimony." Md. Rule 5-702.

There was no objection by either party regarding each expert's qualifications and I accepted both experts in the respective fields for which they were offered. After hearing both experts' qualifications, I accepted both of them as expert witnesses in the areas of expertise for which they were offered.

Even though accepted as an expert, an expert opinion may nevertheless be tested for bias. As noted by the Court of Appeals of Maryland in *Wrobleski v. de Lara*, 353 Md. 509 (1999):

> The professional expert witness advocating the position of one side or the other has become a fact of life in the litigation process. Practicing lawyers can quickly and easily locate an expert witness to advocate nearly anything they desire. In each part of the country, if you need an expert medical witness to state that plaintiff suffered a whiplash injury, call expert X; if you need a medical expert to dispute that fact, call expert Y. The use of the expert witness has become so prevalent that certain expert witnesses now derive a significant portion of their total income from litigated matters.

Id. at 515-516 (internal citations omitted). I heard nothing during the hearing to suggest either expert was biased in his views, either in favor of the Board or against the Respondent or vice versa. The experts had no apparent interest in the outcome of the hearing and had no role in determining whether or not the Respondent will be sanctioned. While each expert was compensated for their time to review the case and testify at the hearing, there was no evidence either witness derives a significant amount of his income by testifying as an expert in matters such as the instant case.

As to each expert's testimony, I evaluated the evidence and testimony before me, noting that both experts, as well as the Respondent, are more familiar than I am with the technical, scientific, and medical terms used. I deferred to the experts on some of the issues before me, and evaluated the expert opinions of each expert as to whether the Respondent failed to meet the standard of care for quality medical care, failed to keep adequate medical records, or grossly overutilized health care services. Each expert offered opinions as to each of these areas, and I gave those opinions the weight I determined they deserved, but did not adopt either of the experts' opinions as my own. My summary as to the experts' opinions as to each area explored, in relation to the charges, is below.

Standard of Care as to Cryosurgery and Cervicitis

For the Board, Dr. [redacted] explained that cervicitis, an inflammation of the uterine cervix, is a common condition treated by gynecologists, and presents itself either as acute or chronic. Dr.

explained that acute cervicitis is typically treated with medication because the cause is almost always a type of infection that can be treated with medications. Chronic cervicitis also can be treated with medications but often can be treated by tissue destruction. He also explained that while cryosurgery is a method of tissue destruction, it is more commonly used in gynecology to treat pre-cancerous conditions of the cervix and not widely used to treat cervicitis. Dr. indicated in his testimony that cryotherapy is an accepted technique to treat chronic cervicitis, but he was unaware of any instances in his training and experience where cryosurgery was used to treat chronic cervicitis in the last twenty years.

Dr. noted in the Respondent's treatment of Patient 5 and 6 that in his opinion the Respondent did not provide quality medical care to the patients when she performed cryosurgery for cervicitis. In particular, Dr. noted that the medical records he reviewed did not indicate whether the cervicitis was chronic or acute, or whether any less invasive treatments were attempted before performing cryosurgery. Patient 5's young age, starting at age 14, also gave Dr. pause with respect to such a procedure being performed.

Dr. noted that in terms of cervicitis, according to his review of literature, there is no "standard definition" of cervicitis. Dr. did not distinguish between acute or chronic cervicitis. Moreover, Dr. noted several articles that showed cryotherapy as an accepted treatment for cervicitis, although in each instance the scholarly studies involving cryotherapy to treat cervicitis involve the treatment of *chronic* cervicitis only.

Failure to Maintain Medical Records

For the Board, Dr. reviewed and testified extensively, with references to the exhibits, as to the adequacy of the medical records for Patients 1 and 3. In particular, Dr. detailed inconsistencies as to the record, in particular internal inconsistencies on the same record for the same date where subjective symptoms sometimes did not match objective diagnoses or

treatments ordered. In Dr. [redacted]'s opinion, this resulted in inadequate record keeping on the part of the Respondent, because it put a subsequent physician reviewer at a disadvantage to provide a clear continuity of care. As Dr. [redacted] explained, in reviewing the records for Patients 1 and 3, he would feel the need to recreate a complete history for each patient because of the inconsistencies in each of their records.

Dr. [redacted], however, disagreed with Dr. [redacted]. In reviewing the records of Patients 1 and 3, he noted that the internal inconsistencies noted by Dr [redacted] were more issues related to whether such symptoms were placed in the appropriate "box" in the record, or are somehow "mislabeled" within the record, and was not a holistic reading of the record. In Dr. [redacted]'s opinion, and through his review of Patient 1 and 3's records, he could elicit all the information needed to provide continued care to each patient.

Gross Overutilization of Health Care Services

Dr. [redacted] testified that in his opinion the five cryosurgeries performed on Patient 5 constituted a gross overutilization of health care services. This was based on his prior testimony, noted above, that cryosurgery in general is not a widely accepted treatment for cervicitis. The performance of five such cryosurgeries, therefore, constituted a gross overutilization of health care services.

As to the use of sonograms with Patients 2 and 5, Dr. [redacted] testified that there were appropriate indications for each sonogram ordered by the Respondent, except for the generic cramping Patient 5 experienced in which a sonogram was ordered. In that instance, Dr. [redacted] found the order for a sonogram unusual, and the follow-up sonograms that occurred with Patient 5 with the same indications from prior sonograms unnecessary. He also had concerns of the timing of the sonograms, in particular Patient 2's initial sonograms, which were six weeks apart. When asked initially, however, whether he believed the sonograms ordered by the Respondent

represented a gross overutilization of health care services, Dr. ███ characterized it as an "overutilization" but not a gross one. He later clarified, in a follow-up question, that he did find it to be a gross overutilization.

Dr. ███ testified that he did not find the Respondent's use of sonograms to be excessive, let alone grossly overutilized. In his opinion, the Respondent was appropriately ordering the sonograms for the various conditions noted for Patients 2 and 5 because the Respondent needed to monitor the various conditions in order to provide quality medical care. As such, and as those conditions continued, the sonograms were necessary and not grossly overutilized.

IV. The Respondent's Testimony

The Respondent testified extensively to her education and work as a gynecologist. She has a diverse patient population, many of whom are younger. She explained that she personally does all of her medical record entries for each patient, and admits in the past she could have done a better job in her record keeping, recently taking a class to improve that skill. She explained that she learned to perform cryosurgery for cervicitis during her residency, and she continues to offer it as a low-cost alternative treatment for cervicitis with few side effects for her patients.

Like Dr. ███, the Respondent views cervicitis as having no standard definition. Indeed, the Respondent emphasized her approach to medical care was to work from what she characterized as a "cookbook" of treatment. In reviewing several of the records during the hearing, the Respondent demonstrated a competent knowledge of her patients, and displayed a compassion for her patient population. There were instances however, particularly during cross-examination, that the Respondent could not cite portions of the medical records to justify her treatment course as to some of the patients in question. In several instances, it was clear that the

Respondent had extensive personal memory and knowledge of treatment of her patients that might not otherwise be recorded in the medical records presented as exhibits at the hearing.

V. Findings as to the Charges

Patient 1

I find the Respondent failed to meet the appropriate standard of care for medical record keeping as to Patient 1. On September 17, 2018, the Respondent recorded that Patient 1 was experiencing hot flashes and reporting getting regular menses with heavy blood loss at times. However, the Respondent's diagnosis of Patient 1 recorded irregular menstruation and cessation of regular menses, the exact opposite of what Patient 1 reported. Moreover, on September 19, 2018, two days after this diagnosis, the Respondent diagnosed Patient with frequent and excessive menstruation, without any explanation, and again completely opposite to what she had diagnosed two days before. This inconsistent record keeping places a reviewing physician in a position that would require a new history and diagnosis, thus disrupting the continuity of care for Patient 1.

Patient 2

I find the Respondent did not grossly overutilize health services in ordering sonograms for Patient 2. In particular, Patient 2's symptoms for an ongoing diagnosis for PCOS are an indication for continued sonograms during her care with the Respondent. While the Board's expert and peer reviewer focused on the timing of the sonograms and the varying reasons recorded in Patient 2's medical records for the sonograms, Dr. [redacted] overlooked the discovery of a cyst on Patient 2's first sonogram and the continued diagnosis and discovery of PCOS on her subsequent sonograms, all of which are indications for continued sonograms to diagnose and treat the condition. In addition, Dr. [redacted] found that while the Respondent's use of sonograms were overutilized, at the hearing he initially hedged when asked if they were *grossly* overutilized,

which indicates to me there was at least some doubt in his mind that the sonograms met the standard of gross overutilization.

Patient 3

I find the Respondent failed to meet the appropriate standard of care for medical record keeping as to Patient 3. Similar to Patient 1, the August 21, 2018 record examined by the peer review provided inconsistent record keeping which would place a reviewing physician in a position that would require a new history and diagnosis. In particular, during the August 21, 2018 visit in which Patient 3 was ordered a sonogram for irregular bleeding, there was no indication in that record or on the record of a prior visit that Patient 3 actually complained of irregular bleeding or menses.

Patient 5

Indeed, the bulk of this hearing focused on the extensive treatment records of Patient 5. Patient 5 had extensive medical issues throughout her treatment by the Respondent, including but not limited to irregular menses, PCOS, vaginitis, cervicitis, and pregnancy. During the course of treatment with the Respondent, Patient 5 had eleven sonograms and five cryosurgeries over the course of five years of treatment.

To that end, I find that the Respondent failed to meet the standard of quality medical care for Patient 5, in particular her use of five cryosurgeries to treat cervicitis. Again, both experts conceded that cryosurgery can be used to treat chronic cervicitis. However, in Patient 5's case, the Respondent never affirmatively diagnosed Patient 5 with chronic cervicitis, despite a continuing course of care for cervicitis spanning several years. The Respondent excuses this by stating that there is no standard definition for cervicitis, which is simply not the case, as cryosurgery is to be used only in rare cases of *chronic* cervicitis. As such, a diagnosis of chronic

cervicitis was required, ruling out other alternative treatments that may be available to treat either acute or cervicitis.

However, I do not find that the Respondent grossly overutilized health services in the performance of the five cryosurgeries for Patient 5. Indeed, I cannot discount that the Respondent was, in fact, treating a course of chronic cervicitis in which cryosurgery may have been the simplest, most accessible, and lowest cost treatment available. While chronic cervicitis is not affirmatively indicated in the records, it is not ruled out either and, therefore, repeated cryosurgeries may have been necessary.

Moreover, I do not find that the Respondent grossly overutilized sonograms in the treatment of Patient 5. Again, while Patient 5 had eleven sonograms over a five year period, she also had multiple conditions that required monitoring, not least of which was the presence of PCOS and cysts. While a portion of the records that drew Dr ████'s focus for Patient 5 may have provided indications such as cramps that normally would not call for a sonogram, the whole history of treatment for Patient 5 did not demonstrate gross overutilization, in particular to treat her ongoing conditions.

Patient 6

I find that the Respondent failed to meet the standard of quality medical care for Patient 6 for the one cryosurgery performed to treat cervicitis. Again, there was no indication as to whether Patient 6's cervicitis was acute or chronic. Given this was the first indication of cervicitis in Patient 6's records, implying a possible acute case of cervicitis, treatment with cryosurgery would be inappropriate based on the standards of the rare usage of cryosurgery to treat *chronic* cervicitis.

However, I do not find that the Respondent grossly overutilized health services in performing one cryosurgery for cervicitis on Patient 6. Performing one cryosurgery procedure,

indicates limited use of cryosurgery as a health service in this instance. Further, Dr. ■ testified that he did not find this one limited use of cryosurgery to constitute a gross overutilization of a health service.

Summary of Findings on Charges

All told, I find the Board has met its burden to sustain the charges against the Respondent for failure to meet the standard of quality medical care, pursuant to section 14-404(a)(22) of the Health Occupations Article, in the treatment of Patients 5 and 6 for cervicitis through the use of cryotherapy. I also find the Respondent failed to keep adequate medical records, pursuant to section 14-404(a)(40) of the Health Occupations Article, for Patients 1 and 3 for the reasons stated above. However, I do not find the Respondent grossly overutilized health services, pursuant to section 14-404(a)(19) of the Health Occupations Article, as to Patients 2, 5, or 6.

The only remaining charge against the Respondent is whether she conducted herself unprofessionally in the practice of medicine pursuant to section 14-404(a)(3) of the Health Occupations Article, and I find she did not. The Board made this charge as a charge based upon the alleged cumulative actions by the Respondent. However, I do not view these cumulative actions by the Respondent as unprofessional. While the Respondent did not engage in complete record keeping or make complete findings to indicate the use of cryotherapy in certain instances, the cumulative record indicates that the Respondent was acting in what she viewed was the best interests of her patients, and not for some other unprofessional purpose.

VI. Sanctions

Disciplinary proceedings against a physician are not intended to punish the offender but rather to protect the public. *McDonnell v. Comm'n on Medical Discipline*, 301 Md. 426, 436 (1984). The Maryland Court of Special Appeals has held that an administrative agency with disciplinary and licensing authority "has broad latitude in fashioning sanctions within [those]

legislatively designated limits" so that it may place conditions on any suspension or probation. *Cornfeld v. State Bd. of Physicians*, 174 Md. App. 456, 486 (2007) (citing *Neutron Prods., Inc. v. Dep't of Env't*, 166 Md. App. 549, 584, cert. denied, 392 Md. 726 (2006) and *Blaker v. State Bd. of Chiropractic Examiners*, 123 Md. App. 243, 264-65, cert. denied, 351 Md. 662 (1998)).

Under sections 14-404(a)(22) and (40) of the Health Occupations Article and the cases cited above, and subject to the Respondent's right to this hearing, a disciplinary panel may reprimand any licensee, place any licensee on probation and establish conditions of probation, or suspend or revoke a license if the licensee 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 or fails to keep adequate medical records as determined by appropriate peer review.

The Board's regulations include a sanctioning matrix that reflects the minimum and maximum penalties for conduct that is subject to disciplinary action. COMAR 10.32.02.10. Under this matrix, the maximum penalty for a violation of section 14-404(a)(22) of the Health Occupations Article is revocation of the Respondent's license, and the minimum penalty is a reprimand. The maximum fine for violation of this section is $50,000.00, and the minimum fine is $5,000.00.

Under this matrix, the maximum penalty for violation of section 14-404(a)(40) of the Health Occupations Article is suspension of the Respondent's license for one year, and the minimum penalty is a reprimand. The maximum fine for violation of this section is $50,000.00, and the minimum fine is $2,500.00.

The Board's regulations also identify mitigating and aggravating factors for imposing a penalty outside of the regulatory range. Mitigating factors include:

(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;
(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.

COMAR 10.32.02.09B(5).

Aggravating factors may include, but are not limited to, the following:

(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.

COMAR 10.32.02.09B(6).

In this case, the Board has stated that it seeks to impose the disciplinary sanction(s) of a reprimand; eighteen months' probation; that the Respondent take a Board approved course in medical recordkeeping to be completed within six months of the Board's final decision; to cease and desist in the performance of cryosurgeries until a course in the appropriate application of cryosurgery is completed within six months of the Board's final decision; supervision by a Board-approved supervisor for the period of one year following the completion of the cryosurgery course; and a $10,000.00 fine. Md. Code Ann., Health Occ. § 14-404(a) (Supp. 2020); COMAR 10.32.02.09A; COMAR 10.32.02.10.

There is a mitigating circumstance I must consider before recommending a sanction. Specifically, the Respondent does not have a previous disciplinary record. COMAR 10.32.02.09B(5)(a). The parties did not raise, nor can I find on this record, any aggravating factors that would affect any sanctions I propose. In any instance, I do not find this mitigating factor sufficiently mitigating to warrant a sanction outside the regulatory range provided in the regulations.

The Board seeks a probationary period of eighteen months, which I find too long given that most of the Respondent's violations stem from overall poor record keeping on her part and not necessarily on poor patient care. Moreover, while the Respondent's lack of disciplinary history does not convince me to stray from the regulatory range provided, I find that a minimum fine provided by the range is sufficient to protect the public.

I find, therefore, that the evidence supports the disciplinary sanctions of a reprimand, one year probation, that the Respondent take a Board approved course in medical recordkeeping to be completed within six months of the Board's final decision, that the Respondent cease and desist in the performance of cryosurgeries until a course in the appropriate application of cryosurgery is completed within six months of the Board's final decision; that the Respondent be supervised by a Board-approved supervisor for the period of six monthsfollowing the completion of the cryosurgery course; and that the Respondent be fined $7,500.00, which represents the combined minimum fine for violations of section 10-404(a)(22) of the Health Occupations article ($5,000.00) and section 10-404(a)(40) of the Health Occupations article ($2,500.00). COMAR 10.32.02.10B.

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude as a matter of law that the Respondent failed to meet appropriate standards for delivery of medical and surgical care in an outpatient facility as determined by peer review, in violation of section 14-404(a)(22) of the Health Occupations Article, and failed to keep adequate medical records in violation of section 14-404(a)(40) of the Health Occupations Article. Md. Code Ann., Health Occ. §§ 14-404(a)(22) and 14-404(a)(40) (2014 & Supp. 2020). As a result, I conclude that the Respondent is subject to disciplinary sanctions of a reprimand with one year probation, including a Board approved course in medical recordkeeping to be completed within six months of the Board's final decision, a cease and desist order in the performance of cryosurgeries until a course in the appropriate application of cryosurgery is completed within six months of the Board's final decision and supervision by a Board-approved supervisor for the period of six months following the completion of the cryosurgery course. *Id.*; COMAR 10.32.02.09 and 10.32.02.10.

I further conclude that the Respondent is subject to a fine of $7,500.00 for the cited violations. COMAR 10.32.02.10B.

PROPOSED DISPOSITION

I **PROPOSE** that charges filed by the Maryland State Board of Physicians against the Respondent on March 27, 2020 be **UPHELD**, with the exception that the Respondent did not grossly overutilize health care services as to Patients 2, 5, and 6, and that the Respondent's conduct did not constitute, in whole or in part, unprofessional conduct in the practice of medicine; and

I PROPOSE that the Respondent be sanctioned by reprimand; probation for one year; that the Respondent take a Board approved course in medical recordkeeping to be completed within six months of the Board's final decision; that the Respondent cease and desist in the

performance of cryosurgeries until a course in the appropriate application of cryosurgery is completed within six months of the Board's final decision; that the Respondent be supervised by a Board-approved supervisor for the period of six months following the completion of the cryosurgery course; and

I **PROPOSE** that the Respondent be ordered to pay a fine of $7,500.00.

January 5, 2021
Date Decision Mailed

Stephen W. Thibodeau
Stephen W. Thibodeau
Administrative Law Judge

SWT/da
189746

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party adversely affected by this proposed decision may file written exceptions with the disciplinary panel of the Maryland State Board of Physicians that delegated the captioned case to the Office of Administrative Hearings (OAH), and request a hearing on the exceptions. Md. Code Ann., State Gov't § 10-216(a) (2014); COMAR 10.32.02.05. Exceptions must be filed within fifteen (15) days of the date of issuance of this proposed order. COMAR 10.32.02.05B(1). The exceptions and request for hearing must be addressed to the Disciplinary Panel of the Board of Physicians, 4201 Patterson Avenue, Baltimore, MD, 21215-2299, Attn: Christine A. Farrelly, Executive Director.

A copy of the exceptions should be mailed to the opposing attorney, and the other party will have fifteen (15) days from the filing of exceptions to file a written response addressed as above. *Id.* The disciplinary panel will issue a final order following the exceptions hearing or other formal panel proceedings. Md. Code Ann., State Gov't §§ 10-216, 10-221 (2014); COMAR 10.32.02.05C. The OAH is not a party to any review process.

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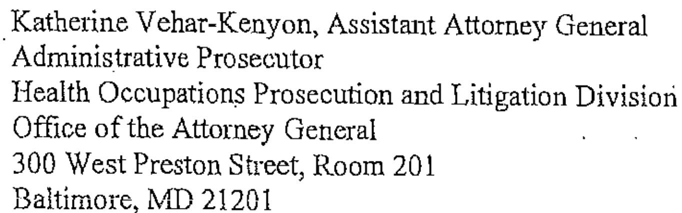

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