IN THE MATTER OF	*	**BEFORE THE**
EYAKO WURAPA, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D76100	*	**Case Number: 2222-0051A**

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

ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of **EYAKO WURAPA, M.D.** (the "Respondent"), License Number D76100, to practice medicine in the State of Maryland.

Panel A takes such action pursuant to its authority under Md. Code Ann., State Gov't § 10-226(c) (2021 Repl. Vol.), concluding that the public health, safety, or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

Based on information received by, and made known to Panel A, and the investigatory information obtained by, received by and made known to and available to Panel A, including the instances described below, Panel A has reason to believe that the following facts are true: [1]

[1] The statements regarding Panel A's investigative findings are intended to provide the Respondent with notice of the basis of the suspension. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

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 May 21, 2013, under License Number D76100. The Respondent's license is currently active through September 30, 2023.

2. The Respondent is board-certified in family medicine.

3. At all times relevant hereto, the Respondent was employed as a physician at an urgent care center that provides immediate walk-in treatment for illnesses and injuries, wellness exams, and employer health services (the "Center")[2] located in Washington County, Maryland.

4. On or about September 10, 2021, the Board received a Mandated 10-Day Report (the "Report") from the Center which reported that the Respondent's employment was terminated following a violation of the Center's policy and procedure and for providing professional services while appearing to be under the influence or otherwise in an unsafe state of mind to practice medicine.

5. On receipt of the Report, the Board initiated an investigation into the allegations.

[2] For confidentiality and privacy purposes, the names of individuals and health care facilities involved in this case are not disclosed in this document. The Respondent may obtain the names of all individuals and health care facilities referenced in this document by contacting the administrative prosecutor.

II. BOARD INVESTIGATION

Respondent's Written Response

6. Shortly after receiving the Mandated 10 Day Report, Board staff reached out to the Respondent and requested that he provide a response to the assertions made in the Report that he appeared to be providing professional services while under the influence or otherwise in an unsafe state of mind.

7. By letter dated October 4, 2021, the Respondent provided the following information:

> During my service in the US Army I sustained a left knee injury. I recently had a procedure to help with the pain and was given pain medications (Percocet) that I have used sparingly for pain control. On the said date I did use the medication due to pain and insomnia. Have since stopped the medication and using motrin 800mg for pain control.

Respondent's Medical Record

8. As part of its investigation, Board staff obtained the Respondent's permission to subpoena his recent hospital records.

9. According to subpoenaed records, on May 5, 2021, the Respondent underwent a left knee arthroscopic medial menisectomy. The Respondent was prescribed Percocet 5/325mg upon discharge.[3]

Quality Assurance/Risk Management File

10. In furtherance of the investigation, Board staff obtained the Quality Assurance/Risk Management file (the "File") the Center maintained on the Respondent.

[3] The record is silent on the number of tablets prescribed.

The File documented that on August 30, 2021, the Respondent reported to the Center for his shift, reporting in late,[4] and saw a few patients. According to the File, the Center Manager contacted the Regional Medical Director (the "RMD") regarding concerns that the Respondent appeared to be under the influence or otherwise in an unsafe state of mind to practice. The RMD contacted the Respondent and after talking to him, restricted him from seeing additional patients.

11. The RMD remotely reviewed the patient charts for the patients the Respondent had already seen that morning, and noted that the "documentation was poor." Additionally, the RMD found that the Respondent had "prescribed an incorrect antibiotic in a patient who had a known allergy for the antibiotic. The patient called out the error during the visit . . . . The patient was upset with the provider's behavior." The RMD noted several other issues with the Respondent's documentation including: inappropriate labs and studies ordered; diagnosis inconsistent with documented history and physical; plan inappropriate for diagnosis; appropriate follow-up plan was not clearly documented.

Interviews of Center Employees Present on August 30, 2021

12. The Board interviewed three (3) Center employees who interacted with the Respondent on August 30, 2021: a medical assistant/radiographer (the "Assistant"), a certified registered nurse practitioner (the "CRNP"), and a registered nurse (the "RN").

13. On January 4, 2022, the Assistant was interviewed by Board staff under oath. The Assistant stated that shortly after the Respondent's knee surgery, she had to

[4] Employee time punches for August 30, 2021, reveal that the Respondent clocked in at 9:02am. According to the Respondent's appointment log, his first patient checked-in at 8:07am.

wake him when he was sleeping at the desk. On that date, the Respondent disclosed to her that he had taken his pain medication that day.

14. On August 30, 2021, the Assistant explained how she once again found the Respondent sleeping at his desk and tapped him on the shoulder to inform him that a patient was waiting for him.

15. It was approximately 10:00am when the Respondent was asked to stop seeing patients and to consent to a breathalyzer. The Assistant explained that at 4:42pm she was asked to perform a breathalyzer on the Respondent. The first breathalyzer was positive (BAC .182) and so was a second conducted at 4:45pm (BAC .175).

16. On January 7, 2022, the CRNP was interviewed by Board staff under oath. The CRNP stated that she had worked with the Respondent approximately ten (10) times including on August 30, 2021. The CRNP added that the Respondent would often come to work "very drowsy" and would be "an hour or two late." On one occasion, approximately one month prior to the incident, the CRNP asked the Respondent why he was so sleepy. The CRNP recalled the Respondent saying that he had knee surgery and had taken his Percocet around 3:00am or 4:00am that morning.

17. Recalling August 30, 2021, the CRNP explained that on other occasions when the Respondent fell asleep at work, she could easily wake him to remind him that he had patients waiting, however on that day, it was different. The CRNP added:

> [H]e was harder to arouse . . . nothing was startling him. Like if you try to wake him . . . he'd be right back to sleep. So, it's, like, he wasn't even there. Like, he didn't hear you at all.
> . . . .

> We have phones going off constantly, people talking, patients coming up to the desk. And he was just slouched down in his chair like this asleep.

18. In addition, the CRNP observed one of the Respondent's patients at the front desk complaining about the care she received from the Respondent that morning. Among the patient's complaints was the fact that the Respondent gave the patient paperwork that had the wrong name on it, he prescribed a medication that she was allergic to, and the medication prescribed did not address the reason for her visit.[5]

19. The CRNP noted that at that time she, the Center Manager, and the Assistant made the decision to alert the RMD of the Respondent's concerning behavior.

20. The CRNP added that after the Respondent was informed that he was no longer permitted to see patients, he sat at his desk for the rest of the day and slept. The CRNP explained that

> [T]here were a couple [of times] that when he woke up, he would wake up and pull a patient – almost like he forgot he wasn't supposed to take the patient . . . I think that happened twice, and I spoke to my manager, I said, you know, he took another patient. And [the RMD] called him right away, told him not to see that patient . . . So I took the patient.

21. On December 23, 2021, the RN was interviewed by Board staff under oath. The RN explained that of the ten (10) or so times she worked with the Respondent, she often observed him to be "sleepy" or "overly tired" and he would sleep while on duty at the Center:

---

[5] Records indicate the patient arrived at the Center complaining of ***lower back pain***. The Respondent diagnosed the patient with ***acute pharyngitis*** and prescribed an antibiotic: "PRESCRIBED cyclobenzaprine 10mg tablet: ***Take 1 tablet (Oral) every 8 hours PRN – Muscle Spasm***; Total 20 (Twenty) tablet[.]" (Emphasis added)

> He would fall asleep in his chair. He'd be sitting there at his computer and just fall asleep. Then wake up easily when you say something, but like, he falls asleep.

22. The RN explained that she once observed a patient waiting at the front desk for some paperwork, slam her fists on the desk and tell the Respondent, who had fallen asleep, to "wake up."

23. Recalling August 30, 2021, the RN confirmed that the Respondent spent much of the day sleeping in a chair in the front of the office, within view of patients.

Respondent Interview

24. On January 14, 2022, the Respondent was interviewed by Board staff under oath with counsel present. The Respondent provided the following information:

a. Following his knee surgery on May 5, 2021, he was prescribed 10-15 tablets of Percocet.

b. He returned to work on May 8, 2021.

c. On August 29, 2021, he went for a run and was experiencing pain. At approximately 9:00pm, he took one Percocet and the pain subsided. At approximately 1:00am on August 30, 2021, he awoke in pain and took some Tylenol.

d. At approximately 2:00am, the Respondent explained that "I was still up, I had a total shift in front of me and I – at that point . . . made the wrong decision of going down[stairs] to take a shot of whiskey. Actually, two."

e. After arriving at work, he saw "maybe one or two patients" and then fell asleep.

f. He was woken up by the Center Manager – "she just woke me up to say, hey, we have some patients. That's when I decided to see patients again."

g. He received approximately three (3) calls from the RMD telling him to stop seeing patients.

h. He did try to see a few "non-medical" patients to "help keep the flow going" but was told once again by the RMD to stop seeing patients.

i. He took a breathalyzer that was positive.

j. He called a friend who lived nearby to drive him home from the Center. The friend drove him home and the friend's wife drove his car so it would not be left at the Center.

k. He gave the remaining four (4) Percocet tablets from his original prescription to a friend who had "run out of his" prescription following surgery.

l. He would often doze off a little at work due to his work schedule, especially if "given the chance to sit down."

25. When asked if he believed he was under the influence of the Percocet and alcohol on August 30, 2021, the Respondent stated: "I've never slept at work, so I must have been."

Maryland Physician Health Program ("MPHP") Records

26. On or about January 14, 2022, the Respondent gave written consent to the Board to access his MPHP records for use in the investigation.

27. On or about October 1, 2019, MPHP received a referral from the Respondent's prior employer, an urgent care center ("Center 2"), documenting concerns regarding the Respondent's use of alcohol prior to his shift. During the shift, the Respondent reportedly had difficulties with the electronic medical record (EMR) and contacted a physician assistant (the "PA") to assist. The PA was unable to assist the Respondent over the phone, so she went to the site. Upon arriving, the PA noted that the Respondent was having difficulty recalling the patients he had seen and what care he had

rendered. The Respondent also smelled of alcohol. The Respondent denied, then admitted that he had been drinking prior to his shift.

28. According to records, the Respondent was contacted by MPHP and explained that in 2019 he was working PRN at Center 2 and on the day in question, he was not scheduled to work. While at a retirement party for a military colleague, Center 2 called him and asked him to come in to cover for an ill physician. He accepted and went to Center 2 directly from the party.

29. On or about December 1, 2021, the Respondent self-referred to MPHP following his termination from the Center. On or about December 13, 2021, the Respondent had an initial evaluation with MPHP staff.

30. On December 15, 2021, the Respondent submitted to a urine toxicology screen as part of the MPHP intake process. On December 30, 2021, the results were confirmed to be positive for alcohol. On January 6, 2022, the lab's medical review officer contacted the Respondent to inform him of the positive result.

31. During the interview with Board staff, the Respondent referenced this positive result and explained:

> Prior to the – the urine test, which I did on the 15th, I was in Philadelphia on the 12th -- my goddaughter's birthday . . . we had some drinks that day.

CONCLUSIONS OF LAW

Based upon the foregoing Investigative Findings, Panel A concludes as a matter of law that the public health, safety, or welfare imperatively requires emergency action,

pursuant to Md. Code Ann., State Gov't § 10-226(c)(2) (2021 Repl. Vol) and Md. Code Regs. ("COMAR") 10.32.02.08(B)(7)(a).

ORDER

It is, by a majority of the quorum of Panel A, hereby:

ORDERED that pursuant to the authority vested in Panel A by Md. Code Ann., State Gov't § 10-226(c)(2) and COMAR 10.32.02.08(B)(7)(a), the Respondent's license to practice medicine in the State of Maryland is hereby **SUMMARILY SUSPENDED;** and it is further

ORDERED that a post-deprivation hearing in accordance with COMAR 10.32.02.08(B)(7) on the summary suspension will be held on **Wednesday, February 9, 2022, at 11:30 a.m.** before Panel A at the Maryland State Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215-0095; and it is further

ORDERED that at the conclusion of the post-deprivation hearing before Panel A, the Respondent, if dissatisfied with the result of the hearing, may request within ten (10) days an evidentiary hearing, such hearing to be set within thirty (30) days of the request, before an Administrative Law Judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031-1301; and it is further

ORDERED that this is an Order of Disciplinary Panel A, and as such, is a **PUBLIC DOCUMENT.** *See* Md. Code Ann., Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Provisions § 4-333(b)(6).

Signature on File

01/27/2022
Date

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians