IN THE MATTER OF	*	**BEFORE THE**
IMMIRNE M. OUWINGA, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D78131	*	**Case Number: 2219-0045B**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of **IMMIRNE M. OUWINGA, M.D.** (the "Respondent"), License Number D78131, to practice medicine in the State of Maryland.

Panel B takes such action pursuant to its authority under Md. Code Ann., State Gov't ("State Gov't") § 10-226(c)(2) (2014 Repl. Vol. and 2017 Supp.) and Md. Code Regs. ("COMAR") 10.32.02.08B(7), concluding that the public health, safety or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

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

I. BACKGROUND

1. The Respondent was originally licensed to practice medicine in Maryland on June 30, 2014, under License Number D78131. The Respondent's latest license was given the expiration date of June 30, 2019.

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[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with reasonable notice of the alleged facts. 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.

2. At all times relevant hereto, the Respondent operated a medical practice named *OT Family Medicine,* which is located at 10339 Southern Maryland Boulevard, Suite 206, Dunkirk, Maryland 20754.

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

II. PRIOR BOARD ACTION

4. In or around December 2015, the Respondent self-reported that she had been arrested for driving while under the influence of alcohol. By letter dated May 9, 2016, the Board issued the Respondent an Advisory Letter.

III. THE COMPLAINT

5. The Board initiated an investigation of the Respondent after receiving a complaint about her, dated September 24, 2018, from the Chief Medical Officer/Vice President of Medical Affairs (the "Complainant")[2] of a health care facility (the "Facility").

6. The Complainant reported that a former patient and friend of the Respondent ("Individual A") reported to him that she had become "alarmed" about the Respondent's behavior in the past two months. Individual A reported concerns about the following incidents:

a. Individual A observed that the Respondent was highly intoxicated when she was invited to the Respondent's residence during the July 4th weekend and witnessed other instances when the Respondent was inebriated;

b. The Respondent engaged in attempts at inappropriate physical contact with Individual A during the July 4th weekend;

c. Individual A discovered prescription bottles with the names of other patients in the Respondent's bedroom and personal office;

[2] For confidentiality reasons, the name of the Complainant, medical facilities and other individuals/entities will not be disclosed in this document. The Respondent may obtain the identity of any individual/entity referenced herein by contacting the assigned administrative prosecutor.

d. Individual A observed the Respondent using a marijuana vape pen, possibly accepts marijuana from patients and was asked by the Respondent to obtain a medical marijuana card;

e. Individual A recounted that one of the Respondent's family members implored her to ensure that the Respondent took certain medications the family member laid out for her to take;

f. Individual A stated that the Respondent stores alcohol in her office, accepts alcohol from patients as gifts, and has offered alcohol to a patient;

g. The Respondent is having an unprofessional relationship with a patient; and

h. The Respondent became physically violent toward and struck an office colleague ("Individual B") in the face, who subsequently left his employment with her.

7. The Complainant provided notes of his interview of Individual A. The Complainant stated that he had no way of knowing how accurate Individual A's accounts were, but that from a "medical staff and community safety perspective, these allegations are very concerning."

IV. SUBSEQUENT BOARD INVESTIGATION

8. As part of the Board's investigation, Board staff conducted an under-oath interview of Individual A on October 29, 2018. Individual A confirmed and reiterated the statements she provided to the Complainant. Individual A also provided Board staff with photographs of a patient's prescription bottle she discovered while at the Respondent's residence. The medication, which the Respondent prescribed, was for Zolpidem 10 mg (Zolpidem is a sedative-hypnotic which is prescribed on a short-term basis for insomnia). Individual A also provided another photograph of a prescription bottle; the label on the prescription bottle is partially worn off and does not show the patient's name.

9. Board staff conducted an under-oath interview of Individual B on November 7, 2018. Individual B stated that he began working for the Respondent in or around April 2018 and that thereafter, tensions arose because the Respondent was failing to create patient charts and was not submitting bills for services. Individual B confirmed that the Respondent struck him in the face in or around August 2018 at the practice location after going through his cell phone and discovering text messages between him, Individual A and a family member of the Respondent in which they discussed a possible intervention regarding the Respondent's alcohol use. Since the incident, Individual B stated that he has not returned to the Respondent's practice. Individual B also reported that the Respondent admitted to him that she had engaged in an unprofessional relationship with a patient. Individual B also noted that one morning when he arrived at the office, he found the Respondent asleep on an examination bed and noticed two "alcohol bottles" sitting on a nearby table. Individual B stated that the Respondent explained to him that she had been working on completing charts the previous night.

10. Pursuant to its investigation, the Board obtained and evaluated the Respondent's medical record from a physician who provided medical care to the Respondent.

11. The Board also issued a subpoena to the Prescription Drug Monitoring Program ("PDMP"), received information in response to that subpoena, and also reviewed the Respondent's medication profile from an area pharmacy.

12. On November 13, 2018, Board staff notified the Respondent of the Board's investigation and conducted a site visit of the Respondent's practice. Board staff observed/photographed the following:

a. Board staff observed the Respondent's young child in the Respondent's personal office;

b. Board staff observed two plastic bags containing empty prescription pill bottles, most of which were labeled. One of the bags was located in the Respondent's prescription sample room. The second bag was located on the Respondent's desk. The Respondent advised that on occasion, her patients return unwanted medications, which she had staff dispose of. The Respondent stated she uses the bottles collected when she travels on missionary trips to Africa;

c. Board staff observed a single white pill, possibly Clonidine,[3] laying on an end table (approximately four feet high) located in the back left of the Respondent's office. When asked, the Respondent was not able to identify what type of pill or medication it was; and

d. Board staff observed a bottle of gabapentin 300 mg in the Respondent's desk's upper storage area. Gabapentin is a prescription-only medication that is prescribed to treat neuropathic pain. The medication was prescribed by a physician who was not a member of the Respondent's practice. When questioned regarding this, the Respondent claimed that her patient returned the medication to her because of its side effects. The Respondent stated that she does not personally use this medication because it is for "nerve pain."

13. The Board, pursuant to Health Occ. § 14-402(a),[4] referred the Respondent to a Board-approved program (the "Program") for an evaluation. The Program directed the Respondent to undergo a psychiatric/addiction evaluation.

14. On or about December 20, 2018, the Board received a comprehensive evaluation report regarding the Respondent, dated December 17, 2018.[5] The evaluator stated that he "saw

[3] Board staff identified this medication by the identifying information (U-136) inscribed on the pill. Clonidine is a prescription-only, anti-hypertensive medication.

[4] Health Occ. § 14-402(a) states: In reviewing an application for licensure, certification, or registration or in investigation against a licensed physician or any allied health professional regulated by the Board under this title, the Physician Rehabilitation Program may request the Board to direct, or the Board on its own initiative may direct, any physician or any allied health professional regulated by the Board under this title to submit to an appropriate examination.

[5] In order to maintain confidentiality, the details of the comprehensive report will not be disclosed in this Order, but the report will be made available to the Respondent upon request.

significant evidence that [the Respondent's] personal and professional judgment is impaired" and concluded that she "poses a risk to her patients in the practice of medicine at this time."

15. Based on the above investigative facts, Panel B finds that the Respondent presents a substantial likelihood of a risk of serious harm to the public health, safety and welfare.

CONCLUSIONS OF LAW

Based upon the foregoing Investigative Findings, Panel B of the Board concludes that the public health, safety, or welfare imperatively requires emergency action, and that pursuant to State Gov't § 10-226(c)(2) and COMAR 10.32.02.08B(7), the Respondent's license is summarily suspended.

ORDER

IT IS thus, by Panel B of the Board, hereby:

ORDERED that pursuant to the authority vested in Panel B by State Govt. § 10-226(c)(2)(2014 Repl. Vol. and 2017 Supp.) and COMAR 10.32.02.08B(7), the Respondent's license to practice medicine in the State of Maryland is hereby **SUMMARILY SUSPENDED;** and it is further

ORDERED that in accordance with Md. Code Regs. 10.32.02.08B(7) and E, a post-deprivation initial hearing on the summary suspension will be held on **Wednesday, January 30, 2019, at 8:30 a.m.** at the Board's offices, located at 4201 Patterson Avenue, Baltimore, Maryland, 21215-0095; and it is further

ORDERED that after the **SUMMARY SUSPENSION** hearing before Panel B, 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 a copy of the Order for Summary Suspension shall be filed by Panel B immediately in accordance with Health Occ. § 14-407 (2014 Repl. Vol.); and it is further

ORDERED that this is an Order of Panel B, and as such, is a public document. *See* Health Occ. §§ 1-607, 14-411.1(b)(2) and Md. Code Ann., Gen. Prov. § 4-333(b)(6).

01/15/2019
Date

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