IN THE MATTER OF	*	**BEFORE THE**
DUANE M. STILLIONS, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D78260	*	**Case Number: 2221-0088**

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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 **DUANE M. STILLIONS, M.D.** (the "Respondent"), license number D78260, to practice medicine in the State of Maryland.

Panel B takes such action pursuant to its authority under Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol. & 2020 Supp.) 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]

[1] The statements regarding the Respondent's conduct 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.

BACKGROUND

1. At all times relevant hereto, the Respondent was licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on July 24, 2014. His license is active and is scheduled to expire on September 30, 2021.

2. The Respondent is board-certified in anesthesiology and critical care medicine. From 2014 until January 2021, the Respondent was employed by a health care facility staffing company and primarily practiced as an intensivist at a health care facility located in Montgomery County, Maryland ("Facility A").

3. Prior to being licensed in the State of Maryland, the Respondent held a license in the District of Columbia (D.C.), where the Respondent was employed at a healthcare facility in the D.C. (the "D.C. Facility").

4. In approximately May 2009, the Respondent was terminated from the D.C. Facility after an investigation by the D.C. Facility that determined that the Respondent had misused and diverted controlled dangerous substances (CDS) at the D.C. Facility. A report of the investigation was later obtained by the District of Columbia Board of Medicine ("D.C. Board").

5. On or about August 18, 2009, the Respondent voluntarily surrendered his license to practice medicine in D.C.

6. On or about November 16, 2009, (the "D.C. Board") suspended the Respondent's license for at least two years based on the findings of the report of the D.C. Facility.

7. On or about August 22, 2012, the D.C. Board and the Respondent entered into a Negotiated Settlement Agreement that reinstated the Respondent's D.C. license. The agreement required the Respondent to be supervised by a Board-approved anesthesiologist and to enroll in the D.C. Physician Health Program.

COMPLAINT

8. On or about January 29, 2021, the Board received a Mandated 10-Day Report[2] (the "Complaint") stating that effective January 20, 2021, the Respondent's clinical privileges and medical staff membership at Facility A had been "summarily suspended" based on eyewitness accounts and forensic evidence indicating that the Respondent had "diverted a controlled substance."

9. Based on the Complaint, the Board began an investigation.

INVESTIGATION

10. In furtherance of the investigation, the Board obtained a written response from the Respondent to the Complaint, interviewed witnesses, and obtained the Respondent's personnel records from Facility A. The evidence obtained indicate that on multiple occasions when the Respondent was working on the Surgical Intensive Care Unit (SICU), he diverted controlled dangerous substance ("CDS") from patient IV medication pumps.

11. Included with the Respondent's personnel records were statements to Facility A from two eyewitnesses, both clinical nurses ("Clinical Nurse A" & "Clinical Nurse B"),

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[2] *See* Health Occ. § 14-413.

who directly observed the Respondent diverting a CDS by siphoning from patients' intravenous medication pumps on multiple occasions.

12. Clinical Nurse A reported that on January 3, 2021, she saw the Respondent

> acting weird around an IV pump. He appeared to be manipulating the pump in some way. ... Later that day the same thing happened with the pump for room 8...I could tell he was manipulating the pump in some way. ... This Sunday, January 17, sometime after 4pm I saw him at the medication pump for the patient un room 12 and he was pulling something from the IV. I watched him remove the orange cap and withdrawal [*sic*] something from the tube. He then took the filled syringe and put it in his pocket.

13. Clinical Nurse A further reported that the pump from which the Respondent extracted the fluid contained CDS.

14. Clinical Nurse B reported nearly identical observations, specifically that on the morning of January 16, 2021,

> I was standing outside of room 10. From where I was standing, I saw Dr. Stillions go to the outside of patient room 12 where the patient's medication pump was located. The patient in room 12 is a very sick, vented patient on several drips. Dr. Stillions had a syringe in his hand. At first I thought he was going to give the patient medication. He opened the orange cap and it fell to the floor. I then watched Dr. Stillions attach the syringe to the secondary line and withdrawal [*sic*] the patient's medication. I notice that he filled up a 10 cc syringe with the medication and then put the syringe in his chest pocket. He then took out a second syringe and did the same thing, filling it up with close to 10 cc of the medication. ... The medication associated with this line was [CDS].

15. Clinical Nurse B also reported that the following day, Sunday, January 17, 2021, she observed the Respondent again diverting CDS using the same *modus operandi*:

> When he came out [of the doctors' lounge] he went directly to the supply room first; after the supply room he went straight to the patient's medication pump outside room 12. I was outside room 11 at this time. I watched Dr. Stillions withdrawal [*sic*] a full syringe of [CDS] from the tube. About this time, the charge nurse asked me to fill Dr. Stillions in on the status of the

> patient in room 11. As I spoke to him I noticed that he appeared very hyperactive. After that when he left, I went back to the room 12 pump and I saw again that the orange cap was missing from the [CDS] tube.

16. On or about February 12, 2021, the Board conducted an interview with Facility A personnel under oath. Facility A personnel stated that after receiving the reports of the Respondent's conduct from Clinical Nurses A & B, Facility A conducted a forensic examination of the medication pump outside room 12. Based on the examination, Facility A concluded that "there was an amount of medication missing that we could not account for." The missing medication was the same CDS Clinical Nurses A & B observed the Respondent divert.

17. Facility A personnel also stated in the interview with the Board that the patient in room 12 was under the care of the Respondent when the Respondent was working on the unit. The patient was an intubated COVID-19 patient. During the COVID-19 pandemic, the IV medication pumps are located outside the patient rooms.

RESPONDENT'S WRITTEN RESPONSE

18. On or about February 18, 2021, the Board received a written response from the Respondent regarding the Complaint. In his written response, the Respondent acknowledged misusing CDS in the past and acknowledged that he "obtained" CDS from Facility A. He cited as a reason for his diversion of CDS at Facility A the stress of working as a physician during the COVID-19 pandemic. The Respondent also reported that

immediately after the suspension of his privileges at Facility A, he began a program that includes rehabilitation treatment.

CONCLUSION OF LAW

Based on the foregoing investigative findings, Panel B concludes that the public health, safety or welfare imperatively require emergency action in this case, pursuant to Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol. & 2020 Supp.), and Md. Code Regs. 10.32.02.08(B)(7)(a).

ORDER

Based on the foregoing investigative findings and conclusions of law, it is, by a majority of the quorum of Panel B, hereby:

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

ORDERED that a post-deprivation Summary Suspension Hearing in accordance with Md. Code Regs. 10.32.02.08E has been scheduled for **Wednesday, March 24, at 1:00 p.m.** before Disciplinary Panel B;[3] and be it further

ORDERED that at the conclusion of the post-deprivation Summary Suspension Hearing held 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 held within

[3] The hearing will take place via teleconference due to the COVID-19 pandemic. The Respondent will be informed of the procedure before the hearing.

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 be it further

ORDERED that a copy of this Order for Summary Suspension shall be filed with the Board in accordance with Md. Code Ann., Health Occ. § 14-407 (2014 Repl. Vol. & 2020 Supp.); and be it 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).

Signature on File

03/09/2021
Date

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