IN THE MATTER OF	*	BEFORE THE MARYLAND
PETER DIXON, M.D.	*	STATE BOARD OF PHYSICIANS
Applicant	*	Case Number: 2220-0210

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

FINAL DECISION AND ORDER

On June 12, 2020, pursuant to its authority under § 14-205 of the Maryland Medical Practice Act ("Act"), Disciplinary Panel A of the Maryland State Board of Physicians ("Board") issued a Notice of Intent to Deny Application for Initial Medical Licensure ("Notice") to Peter Dixon, M.D. The Notice was based on Dr. Dixon's interactions with residents and students during a residency program; Health Occ. § 14-404(a)(3)(ii) (unprofessional conduct in the practice of medicine); and Health Occ. § 14-307(b) (good moral character required of licensure applicants).

An evidentiary hearing was held at the Office of Administrative Hearings on May 10, 11, 13, 14 and 17, 2021. The evidence included witness testimony from a licensing analyst on behalf of the State, and five fact witnesses and one expert witness for Dr. Dixon, who also testified on his own behalf. The Administrative Law Judge ("ALJ") also admitted into evidence 7 documentary exhibits offered by the State and 41 documentary exhibits for Dr. Dixon.

In a Corrected Proposed Decision[1] issued on August 18, 2021, the ALJ concluded that the Panel's initial evaluation that Dr. Dixon lacked good moral character was incorrect, but that his actions constituted unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii). The ALJ recommended that the Panel's Intent to Deny the Application be

[1] The ALJ issued a Corrected Proposed Decision on August 18, 2021 to correct a clerical error contained on page 49 of the initial Proposed Decision issued on August 10, 2021.

reversed, and that Dr. Dixon be granted a medical license subject to one-year of probation with ongoing therapy and monitoring during the probationary period.

The State filed written exceptions to the ALJ's Proposed Decision, and Dr. Dixon filed a Response to the State's exceptions. Both parties appeared before Disciplinary Panel B of the Board for an oral exceptions hearing on November 17, 2021. After considering the entire record, including the evidentiary record made before the ALJ, and the written exceptions and oral arguments by both parties, Panel B now issues this Final Decision and Order.

FINDINGS OF FACT

Panel B adopts the ALJ's proposed findings of fact numbered 1-38. *See* ALJ Corrected Proposed Decision, attached as **Exhibit 1.**[2] These facts were proven by a preponderance of the evidence and are incorporated by reference into the body of this document as if set forth in full. The Panel also adopts the ALJ's Discussion and Analysis on pages 12-48 and the middle paragraph on p. 49 of the Corrected Proposed Decision with one modification. The Panel corrects the second sentence in the middle paragraph on page 15 to state that the Board issued a Notice of Intent to Deny Application for Initial Medical Licensure Under the Maryland Medical Practice Act, and adopts that sentence as amended. The remainder of the ALJ's Discussion and Analysis on pages 12-49 of the Corrected Proposed Decision is also incorporated by reference into the body of this document as if set forth in full.

CONSIDERATION OF EXCEPTIONS

The State does not dispute the ALJ's conclusion that Dr. Dixon possesses good moral character or that he is guilty of unprofessional conduct in the practice of medicine but excepts to the ALJ's proposed disposition granting him a medical license with probation, continued therapy and a vocational monitor. The State argues that Dr. Dixon committed inexcusable acts of

[2] The ALJ's Corrected Proposed Decision has been redacted to remove confidential information from public view.

unprofessional conduct, including intimidation and disruptive behavior, which would negatively impact the environment in which health care is provided to patients and the teamwork approach to delivering quality health care. In addition, the State argues that the proposed disposition is insufficient to protect the public and that the findings of unprofessional conduct and the Panel's wide discretion support the denial of a license based on the aggravating factors of Dr. Dixon's deliberate actions, his pattern of unprofessional behavior, and the potential for patient harm. COMAR 10.32.02.09B(6). The State questions the ALJ's rationale for recommending the grant of a license based on the amount of rehabilitation that Dr. Dixon has undergone, arguing that previous attempts to rehabilitate him were unsuccessful.[3] In the alternative, the State contends that if the Panel accepts the ALJ's proposal to grant Dr. Dixon a license, he should be placed on indefinite probation, subject to evaluation by the Maryland Professional Rehabilitation Program ("MPRP"), any treatment deemed necessary, and Board-approved coursework on professionalism and workplace boundaries.

In his Response and Opposition to the State's exceptions, Dr. Dixon essentially does not dispute or deny that he made the statements attributed to him by the medical student and residents[4] during his fourth year of residency at a program in Colorado from July 2018 to May 2019, after which he was suspended and then dismissed from the program. He acknowledges that his conduct was unprofessional. He argues that patient care was not an issue and that the parties agreed before the ALJ there was no evidence that patient care was adversely affected by his

[3] Documentary and testimonial evidence presented at the evidentiary hearing revealed that during his initial three years of residency from 2015-2018 at a Baltimore hospital, Dr. Dixon was placed on a temporary administrative suspension based on a pattern of overly abrupt, critical and condescending interactions and communications with junior residents in the program. Prop. Dec. at 20-21. Dr. Dixon testified that he was mentored and counseled by hospital physicians because of these occurrences and his professional communication issues improved at the Baltimore hospital by the conclusion of his third year of residency before he went to Colorado.

[4] Dr. Dixon's statements and behavior at the Colorado residency program are described on pages 16-18 of the ALJ's Proposed Corrected Decision.

actions. He further argues that the State does not take exception to the ALJ's fact finding or framing of the issues, and that its exceptions are focused solely on whether the ALJ's proposed sanction is appropriate. According to Dr. Dixon, the ALJ's proposed decision to grant him a license with conditions is based not only on the documentary evidence presented by the State and Dr. Dixon but on all the testimony from Dr. Dixon, his supporting mentors and supervisors, and from his therapist. In Dr. Dixon's view, the ALJ relied on an exhaustive and detailed record from a five-day evidentiary hearing to find facts and make credibility assessments in support of her proposed decision. Dr. Dixon also argues that the State barely mentions the record detailing his extensive rehabilitation efforts over the past eighteen months to address the unprofessional communications issues that led to his dismissal from the program. He references prior Board decisions concerning intimidating and disruptive behavior by physicians and requests that the Panel grant his application for a medical license consistent with the conditions set forth in the ALJ's proposed decision.

Based on the testimony of Dr. Dixon and his witnesses at the evidentiary hearing, the Panel agrees with the ALJ that Dr. Dixon's comments and interactions do not indicate a lack of good moral character, and there was no evidence that his conduct adversely affected patient care. In analyzing whether Dr. Dixon's communications with junior residents and students in the residency program constituted unprofessional conduct in the practice of medicine, the ALJ reviewed relevant rulings by the Maryland Court of Appeals. Prop. Dec. at 44-46. For example, in *Board of Physician Quality Assurance v. Banks,* 354 Md. 59 (1999), the Court considered whether the actions of the physician were intertwined with patient care in such a way as to pose a threat to patients or the medical profession. *Banks,* 354 Md. at 73. The Court held that unprofessional conduct is in the practice of medicine when it becomes a threat to the teamwork

approach of healthcare, and in particular when it causes co-workers to avoid interacting with the offending physician. *Id.* at 75. In Dr. Dixon's case, the ALJ determined that there can be no dispute that conversations with colleagues, both during clinical care and in the resident's lounge, are intertwined with medical care. Prop. Dec. at 45. The ALJ found that the types of comments, interactions, and jokes attributed to Dr. Dixon during his residency could cause a toxic environment, and that the general tone and theme of his comments and jokes are unacceptable in any professional setting. *Id.* at 46. Because of the tone and content of Dr. Dixon's comments, the ALJ found that he engaged in intimidation and disruptive behavior that could impact the communication and teamwork approach of health care, and that his behavior at the Colorado residency program constituted unprofessional conduct in the practice of medicine. *Id.* at 47. The Panel agrees. Dr. Dixon's comments and behavior compromised his professional responsibilities as a teaching physician and are inimical to the standards of the medical profession.

The Court of Appeals has also held that the meaning of such terms as "unprofessional conduct" is "determined by the 'common judgment' of the profession as found by the professional licensing board." *Finucan v. Maryland Board of Physician Quality Assurance,* 380 Md. 577, 593 (2004). The *Finucan* Court further stated that unprofessional conduct "refers to . . .conduct which is unbecoming a member in good standing of a profession." *Finucan,* 380 Md. at 593. The Panel disagrees with testimony from some of Dr. Dixon's fact witnesses that his repeated disruptive interactions and communications can be characterized simply as mistakes or isolated bad judgment. In a contested case, the "[t]he agency . . . may use its experience, technical competence, and specialized knowledge in the evaluation of evidence." Md. Code Ann., State Gov't § 10-213(i). Based on its experience and specialized knowledge in practicing medicine, the Panel concludes that Dr. Dixon's disruptive behavior, which included an

established pattern of making overly critical, demeaning, condescending, and intimidating statements to those below him on the professional ladder, is not only unbecoming a member in good standing of the medical profession, but is commonly understood in the field as unprofessional conduct.

In determining whether to grant Dr. Dixon's application for a medical license, Panel B has considered the entirety of the documentary and testimonial evidence in this case, including the presentations of both parties at the exceptions hearing. The Panel has reviewed and considered Dr. Dixon's therapeutic and educational efforts to rehabilitate himself since his dismissal from the Colorado residency program. Following a referral to the Colorado Physicians' Health Program, he participated in seven psychotherapy sessions from May to July 2019, to address his repeated difficulties with his communications style and relapse into poor interpersonal interactions. He returned to Maryland, applied for a medical license, and voluntarily reached out to a Health Program for a consultation. Based on the Health Program's referrals, Dr. Dixon successfully completed a ten-week group therapy program - Advancing Emotional Intelligence - from October to December 2019, to refine communication skills. He also attended multiple other courses in 2019, 2020 and 2021, including courses on Managing Disruptive Physicians' Behavior, a Program for Distressed Physicians, and continuing medical education courses to stay abreast of medical terminology, adaptation, and current research. Dr. Dixon also attended a clinical conference hosted annually by the American College of Surgeons in 2020.

In October, 2019, he began and has since continued in weekly and bi-weekly individual counseling and therapy sessions with a licensed clinical social worker and psychotherapist, to specifically address the causes of his improper behavior, and his problematic interactions and

communications. His therapist opined that Dr. Dixon is honest about his poor behavior in his work environment, that he acknowledged the unprofessional and harsh nature of his communications, was open and receptive to the therapeutic process, and was very diligent in his efforts to change. According to the therapist, Dr. Dixon has gained insight into and can identify his triggers for unprofessional behavior, verbalize and manage them when challenged, and take a step back before acting so as to handle them professionally. The therapist also opined that he would benefit from ongoing therapy in the future.

In his testimony, Dr. Dixon admitted that his communication with junior residents was harsh or brash or insensitive, that his racial insensitivity and poor attempts at humor do not belong in the workplace, and that such commentary should not have been part of his vernacular. He acknowledged that it is absolutely imperative for a surgeon to be able to communicate effectively with his team. According to Dr. Dixon, he has had ample opportunity since 2019 to reflect on his communications and conduct and has been given time to change. Based on his coursework and therapy, he expressed unequivocal confidence that his behavior will not recur.

DISPOSITION

The issue before the Panel is whether Dr. Dixon has adequately taken responsibility for his unprofessional and disruptive behavior and whether the Panel is reassured that he is capable of practicing medicine without violating the standards of professional conduct. At the evidentiary and exceptions hearings, Dr. Dixon took responsibility for his actions and testified sincerely and credibly regarding the inappropriate nature of his repeated violations. The Panel appreciates Dr. Dixon's acknowledgment that the types of comments, jokes, and interactions attributed to him by medical students and residents are inappropriate in any workplace. Based on its evaluation of the evidence, the commendable aspects of Dr. Dixon's career, his undisputed clinical and surgical

skills, his candor during the evidentiary and exceptions proceedings, and his extensive efforts since his dismissal in May 2019 to address the causes of his disruptive conduct, the Panel is satisfied that he has made, and continues to make, earnest rehabilitative progress. Dr. Dixon appears to be genuinely invested in and committed to preventing any recurrence of his conduct. He has expressed meaningful insight and reflection into his problematic communication issues and appears capable of integrating his own risk factors with the pressures of his professional responsibilities as a physician and surgeon.

The Panel has considered the aggravating and mitigating factors in this case and recognizes that Dr. Dixon self-reported the dismissal from his residency on his application, admitted his misconduct, was cooperative during the Board's investigation, implemented remedial measures to correct his unprofessionalism, and exhibits rehabilitative potential. COMAR 10.32.02.09B(5). The Panel believes that he is sincere in his commitment to remedy his behavior and has in place concrete, meaningful, rehabilitation plans to fulfill his professional obligations if granted a license. The mitigating factors weigh in favor of granting Dr. Dixon a license with appropriate and specific conditions to ensure his continuation in therapy and monitoring. The Panel will grant Dr. Dixon a medical license with a Reprimand and subject to conditions including a one-year period of probation and referral to the Maryland Professional Rehabilitation Program ("MPRP").

CONCLUSIONS OF LAW

Based on the findings of fact and discussion of Dr. Dixon's response to the State's exceptions, as set forth above, Disciplinary Panel B concludes that Dr. Dixon is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii).

The Panel does not conclude that Dr. Dixon lacks good moral character under Health Occ. § 14-307(b).

ORDER

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

ORDERED that the Application of Peter Dixon, M.D., to practice medicine in Maryland is **GRANTED**; and it is further

ORDERED that Dr. Dixon is **REPRIMANDED**; and it is further

ORDERED that Dr. Dixon is placed on **PROBATION** for a minimum of **ONE (1) YEAR.**[5] During probation, Dr. Dixon shall comply with the following terms and conditions:

1. Dr. Dixon shall enroll in the Maryland Professional Rehabilitation Program ("MPRP") as follows:
   - (a) Within 5 business days of the effective date of this Final Decision and Order, Dr. Dixon shall contact MPRP to schedule an initial consultation for enrollment;
   - (b) Within 15 business days of the effective date of this Final Decision and Order, Dr. Dixon shall enter into a Participant Rehabilitation Agreement and Participant Rehabilitation Plan with MPRP;
   - (c) Dr. Dixon shall fully and timely cooperate and comply with all MPRP's referrals, rules, and requirements, including, but not limited to, the terms and conditions of the Participant Rehabilitation Agreement(s) and Participant Rehabilitation Plan(s) entered with MPRP, and shall fully participate and comply with all therapy, treatment, evaluations, and screenings as directed by MPRP;
   - (d) Dr. Dixon shall sign and update the written release/consent forms requested by the Board and MPRP, including release/consent forms to authorize MPRP to make verbal and written disclosures to the Board and to authorize the Board to disclose relevant information from MPRP records and files in a public order. Dr. Dixon shall not withdraw his release/consent;

[5] If Dr. Dixon's license expires during the period of probation, the probation and any conditions will be tolled.

(e) Dr. Dixon shall also sign any written release/consent forms to authorize MPRP to exchange with (i.e., disclose to and receive from) outside entities (including all of Dr. Dixon's current therapists and treatment providers) verbal and written information concerning Dr. Dixon and to ensure that MPRP is authorized to receive the medical records of Dr. Dixon, including, but not limited to, mental health and drug or alcohol evaluation and treatment records. Dr. Dixon shall not withdraw his release/consent;

(f) Dr. Dixon's failure to comply with any of the above terms or conditions, including terms or conditions of the Participant Rehabilitation Agreement(s) or Participant Rehabilitation Plan(s), constitutes a violation of this Final Decision and Order; and it is further

ORDERED that a violation of probation is a violation of this Final Decision and Order; and it is further

ORDERED that Dr. Dixon shall not apply for early termination of probation; and it is further

ORDERED that after the minimum period of a **ONE (1) YEAR** probation has passed, and after Dr. Dixon has complied with all terms and conditions of probation, and upon a report from MPRP to the Board that Dr. Dixon has successfully complied with all of the requisite referrals and treatment, Dr. Dixon may submit a written petition to the Board requesting termination of probation. Dr. Dixon may be required to appear before the disciplinary panel to discuss his petition to terminate the probation. The disciplinary panel may grant the petition to terminate the probation through an order of the disciplinary panel, if Dr. Dixon has complied with all of the probationary conditions, and there are no pending complaints related to the Notice of Intent to Deny Application for Initial Medical Licensure; and it is further

ORDERED that if Dr. Dixon allegedly fails to comply with any term or condition imposed by this Final Decision and Order, Dr. Dixon shall be given notice and an opportunity for a hearing. If the disciplinary panel determines that 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 the disciplinary panel determines that there is no genuine dispute as to a material fact, Dr. Dixon shall be given a show cause hearing before a disciplinary panel; and it is further

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

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

ORDERED that the effective date of this 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 the disciplinary panel which has imposed the terms and conditions of this Order, and it is further

ORDERED that this Final Decision and Order is a **PUBLIC** document pursuant to Health Occ. § 1-607, § 14-411.1(b)(2), and Gen. Prov. § 4-333(b)(6).

03/02/2022
Date

Signature On File

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

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 14-408, Dr. Dixon has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within thirty (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. Dixon 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:

Noreen Rubin
Assistant Attorney General
Maryland Department of Health
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

Exhibit 1

MARYLAND STATE BOARD OF	*	BEFORE ERIN H. CANCIENNE,
PHYSICIANS	*	AN ADMINISTRATIVE LAW JUDGE
v.	*	OF THE MARYLAND OFFICE
PETER DIXON, MD,	*	OF ADMINISTRATIVE HEARINGS
APPLICANT	*	
LICENSE No.: Unlicensed	*	OAH No.: MDH-MBP1-70-20-17967

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CORRECTED PROPOSED DECISION[1]

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

On June 12, 2020, the Maryland State Board of Physicians (Board) notified Peter Dixon, M.D. (Applicant) of its intent to deny his application for Initial Medical Licensure (Application) pursuant to the State law governing the practice of medicine. Md. Code Ann., Health Occ. §§ 14-101 *et seq.* (2014 & Supp. 2020). The Board based its intent to deny the Application on its authority under section 14-205 of the Health Occupations Article; specifically, it found that the Applicant violated sections 14-307 and 14-404 of the Health Occupations Article. *Id.* § 14-205(b)(3)(i) (Supp. 2020); *Id.* § 14-307 (b) (applicant shall be of good moral character); *Id.* § 14-404(a)(3)(ii) (engaging in unprofessional conduct in the practice of medicine).

On August 25, 2020, the Board delegated the matter to the Office of Administrative Hearings (OAH) for a hearing on the Board's intent to deny the Application. The Board further

[1] The Proposed Decision issued on August 10, 2021 contained a clerical error on page 49. The Proposed Decision mistakenly read "The Applicant shall continue therapy with [redacted] at least two times a week." (Emphasis added). The Proposed Decision should have read, "The Applicant shall continue therapy with [redacted] at least two times a month." (Emphasis added). This Corrected Decision is issued to correct that clerical mistake.

delegated the authority to the OAH to issue Proposed Findings of Fact, Proposed Conclusions of Law, and a Proposed Disposition.

On September 24, 2020, I issued a Scheduling Order following a telephone scheduling conference that occurred on September 21, 2020. Michael Brown, Assistant Attorney General and Administrative Prosecutor, appeared on behalf of the State of Maryland (State). Kenneth Armstrong, Esquire, appeared on behalf of the Applicant, who was not present.

On May 10, 11, 13, 14 and 17, 2021 I held a contested case hearing at the OAH in Hunt Valley, Maryland.[2] Health Occ. § 14-405(a) (Supp. 2020); COMAR 10.32.02.04. Mr. Armstrong represented the Applicant, who was present. Mr. Brown represented the State. I closed the record on May 21, 2021 after allowing the parties time to submit written memoranda of law.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act (APA), 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; and COMAR 28.02.01.

ISSUES

1. Whether the Applicant's conduct constitutes unprofessional conduct in the practice of medicine under Md. Code Ann., Health Occ., §14-404(a)(3)(ii).

2. Under Md. Code Ann., Health Occ., §14-205, whether the Applicant's conduct constitutes a reason that is grounds for action under Md. Code Ann., Health Occ., §14-404(a)(3)(ii).

3. Whether, pursuant to Md. Code Ann., Health Occ. 14-307(a) and (b), the Applicant, in light of any established conduct, is of good moral character.

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[2] Counsel for both parties, the Appellant, and myself were in person in Hunt Valley. Some of the witnesses testified remotely through the Webex videoconferencing platform, but others testified in person in Hunt Valley.

SUMMARY OF THE EVIDENCE

Exhibits

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

State Ex. 1 - Memorandum from Philip Thomas, Licensure Analyst, to Nicolas Johansson, Principal Counsel, Health Occupations Prosecution and Litigation Division, with attached Report of Investigation, February 13, 2020

State Ex. 2 - Application, August 8, 2019[3]

State Ex. 3 - Dismissal from HealthONE [redacted] Medical Center General Surgery Residency, May 28, 2019; Note to the Applicant's MedHub File, May 29, 2019; Disciplinary/Corrective Action Form, undated;[4] Letter to "Whom it May Concern"[5], May 16, 2019; Letter to the Applicant, May 16, 2019; The General Surgery Milestone Project (Milestone Project) documents, July 2015 edition;

State Ex. 4 - Minutes from May 9, 2019 Remediation Meeting

State Ex. 5 - Remediation Notification, May 9, 2019; Referral to CPHP for Professionalism Issues, May 9, 2019; IX. Remediation,[6] July 1, 2018 – June 30, 2019;[7] X. Grievance, July 1, 2018 – June 30, 2019; Certification of receipt of the summary of the Student Complaint Letter, May 9, 2019; Excerpts from the Student Complaint Letter, undated; HCA Healthcare NRMP and NMS 2019,[8] February 27, 2019; Email from Joyce Davidson, LCSW, Director of Clinical Services, Colorado, Physician Health Program, May 8, 2019; Letter from [redacted], medical student, undated.

State Ex. 6 - Meeting notes, November 29, 2018 and September 18, 2018

State Ex. 7 - Initial Application for Licensure, Explanations to Questions 16b, c, e, f, g, h, n, 13a, and 13c, August 8, 2019

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[3] The Application has page numbers at the top (format Page x of 9) and a page number at the bottom center. Page number references are to the bottom center number. Pages 8 and 9 are both of questions 16a-l. Pages 10 and 11 are both of questions 16m-17e. There are duplicates of these pages because the Application as initially submitted had blank spaces (pp. 9 and 11) and a completed version of these pages (pp. 8 and 10) were submitted upon request.

[4] This document states that the termination was effective May 28, 2019, but is not signed or dated.

[5] There is no signature on this document to determine the exact author or recipient. However, the last sentence indicates it is from "the General Surgery Residents at [redacted] Medical Center", and that the letter was submitted to "program leadership."

[6] Pages 3 and 4 of this exhibit appear to be sections from a larger document. The name of the larger document, and the remainder of that presumed document is not in evidence.

[7] This document is signed by the Applicant and appears to be dated May 9, 2018. It is unclear if that date is an error and should be May 9, 2019.

[8] HCA means Hospital Corporation of America. The explanations for the other acronyms were not provided.

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

App. Ex. 1 - Letter of Recommendation from Dr. Andrew Pearle, August 29, 2011

App. Ex. 2 - Letter of Recommendation from Dr. David Chalnick, September 28, 2011

App. Ex. 3 - Letter of Recommendation from Dr. Robin Gehrmann, September 28, 2011

App. Ex. 4 - Letter of Recommendation from Dr. Joseph Benevenia and Dr. Wayne Berberian, October 20, 2011

App. Ex. 5 - Medical Student Performance Evaluation by James Hill, Ph.D., November 2011

App. Ex. 6 - Letters of Recommendation from Dr. Kenneth Swan, September 2, 2012, and June 29, 2013

App. Ex. 7 - Letter of Recommendation from Dr. Dorian Wilson, September 14, 2012

App. Ex. 8 - Letter of Recommendation from Dr. Eric Lazar, July 11, 2013

App. Ex. 9 - Letter of Recommendation from Dr. Mark Nolan Hill, October 7, 2013

App. Ex. 10 - Letter of Recommendation from Dr. Stephen Kavic, September 10, 2014

App. Ex. 11 - Letter of Recommendation from Dr. Mayur Narayan, September 19, 2014

App. Ex. 12 - Letter of Recommendation from Dr. Devinder Singh, October 2, 2014

App. Ex. 13 - Letters of recommendation from Dr. Gerald M. Hayward, January 6, 2018, May 2, 2018, and March 27, 2020[9]

App. Ex. 14 - Letter of recommendation from Dr. Gerald Hayward, March 27, 2020

App. Ex. 15 - Letter of Recommendation from Dr. Michael A. Zatina, January 20, 2018

App. Ex. 16 - Letter of Recommendation from Dr. Eugene J. Schweitzer, January 25, 2018

App. Ex. 17 - Professional Mentor Report from Dr. Isam Hamdallah, May 11, 2018

App. Ex. 18 - Letter of Recommendation from Dr. Emmett L. McGuire, May 10, 2019

App. Ex. 19 - Letters of Recommendation from Dr. R. Dewayne Edwards, September 25, 2019, and February 6, 2020

App. Ex. 20 - Letter of Recommendation from Dr. Isabelle M. Audet, October 29, 2019

[9] These letters were compiled into one document dated March 30, 2020.

App. Ex. 21 - Letter of Recommendation from Dr. Andrew Demeusy, March 23, 2020

App. Ex. 22 - Letter of Recommendation from Dr. Johnny Cheng, April 6, 2020

App. Ex. 23 - Letter of Recommendation from Dr. Thomas J. Cusack, April 6, 2020

App. Ex. 24 - Not offered[10]

App. Ex. 25 - Letter of Recommendation from Dr. George T. Grace, April 9, 2020

App. Ex. 26 - Letter of Recommendation from Dr. Jonathan S. Gallen, April 10, 2020

App. Ex. 27 - Offered, not admitted[11]

App. Ex. 28 - A. Medical Risk Management, Inc. Certification of Completion of Managing Disruptive Physicians Behavior, May 10, 2020

B. The Center for Professional Health – B29 Team Behavior Report, January 25, 2021; The Center for Professional Health Certification of attendance, Program for Distressed Physicians, April 29, 2021[12]

C. American College of Surgeons, Division of Education, Certificate of Completion, Virtual 2020 Clinical Congress, October 3-7, 2020

D. Physician Continuing Medical Education Certificates from various courses on dates between August 31, 2019 and April 22, 2021

App. Ex. 29 - Aggregate Evaluation Reports by Faculty, July 1, 2019 and January 10, 2019; General Surgery Residency Program, Semi-Annual Intern and Resident Evaluation Form by Dr. Quan and Dr. McGuire, January 10, 2019; Letter of Recommendation from Dr. Emmett McGuire to American College of Surgeons for Residence as Teachers and Leaders course, January 4, 2019

App. Ex. 30 - Evaluation Form by Kristen Geis, RN CNC, May 5, 2019

App. Ex. 31 - Curriculum Vitae of the Applicant, as of April 2021

App. Ex. 32 - Letter from Psy.D., March 26, 2020

App. Ex. 33 - Letter from , Ph. D., March 23, 2020

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[10] I retained the exhibit to preserve the record.

[11] This Exhibit is a Consent Order in a case involving Physician (first name redacted to preserve the Physician's privacy), issued July 6, 2020. While it was not admitted as evidence, it will be maintained with the file as part of the record.

[12] This included a 3-day program from January 27-29, 2021, and follow up sessions on March 1, 2021, and April 19, 2021. An additional follow up session was scheduled for July 19, 2021, however, this was after the hearing date and the close of the record.

App. Ex. 34 - Progress Reports from [redacted] LCSW-C, various dates[13]

App. Ex. 35 - Letter from [redacted] LCSW-C, Senior Clinical Manager, [redacted] ([redacted]), July 22, 2020

App. Ex. 36 - [redacted] Report, various dates

App. Ex. 37 - Letter from Loren Scheininger, Sponsor from Alcoholics Anonymous, May 5, 2021; Letter from Dr. J. Greg Hobelmann, May 3, 2021

App. Ex. 38 - Archived General Surgery Defined Category and Minimum, from HCA HealthOne/[redacted] Medical Center Program for the Applicant, as of February 28, 2020

App. Ex. 39 - National Practitioner Data Bank, Response to Self-Query, May 10, 2020

App. Ex. 40 - Letter of Recommendation from Sofia Studer, R.N, BSN, PCCN, June 18, 2020

App. Ex. 41 - State of Colorado, Licensee information for the Applicant, as of April 28, 2021

App. Ex. 42 - Offered, not admitted[14]

App. Ex. 43 - [redacted] Milestone Project Report, June 11, 2018; Letter from [redacted] regarding the Applicant's good standing, March 6, 2018; Shock Trauma Team Clinical Rotation Evaluation, September 18, 2017

App. Ex. 44 - Not offered nor admitted.[15]

App. Ex. 45 - Shock Trauma Team Clinical Rotation Evaluation, September 18, 2017

Testimony

Phillip Thomas, Licensing Analyst, Board, testified on behalf of the State.

The Applicant testified in his own behalf, and presented the following witnesses:

- Dr. Gerald Hayward
- Dr. Roy Edwards
- Dr. Isabel Audet
- [redacted] whom I accepted as an expert in the field of social work

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[13] Some of the reports have clear dates on them, but others have no dates, or only a month and not a year.

[14] This document is an email chain between [redacted] and the Applicant dated July 9 and 31, 2020. It was not admitted due to an objection regarding its relevance. I sustained the objection as the email was a thank you letter from the Applicant and a response from [redacted] but I retained the exhibit to preserve the record.

[15] This document is a set of Colorado Revised Statutes 2020, specifically, Title 12 Professions and Occupations, Article 240: Medical. While this was not offered or admitted as an exhibit, the document will be maintained with the file for reference and easy access for the laws of Colorado for any further review by the Board.

- Dr. Andrew Demeusy
- Dr. James Cusack

PROPOSED FINDINGS OF FACT

I find the following proposed facts by a preponderance of the evidence:

1. On November 6, 2011, the Applicant was arrested and charged with Assault by Auto in conjunction with driving under the influence and a resulting motor vehicle accident in New Jersey. On October 15, 2012, he pled guilty to a disorderly persons offense of simple assault and driving under the influence. As a result, he participated in and completed a five-year contract with the New Jersey Professional Assistance Program.[16]

2. Since July 31, 2012, the Applicant has been sober. The Applicant continues to attend Alcoholics Anonymous meetings voluntarily and maintains a sponsor.

3. From July 2018 to May 9, 2019, the Applicant was a fourth-year surgical resident at HealthONE [REDACTED] Medical Center ([REDACTED] Medical Center)[17] in Colorado.

4. Between July 2018 and May 2019, the Applicant worked at different hospitals as part of his residency program for [REDACTED] Medical Center.

5. For the month of July 2018, the Applicant was assigned to [REDACTED] Medical Center ([REDACTED]) for a colorectal surgery rotation. The Applicant was the only resident at [REDACTED] during July 2018.

6. For the month of August 2018, the Applicant was assigned to [REDACTED] Medical Center for a subspeciality, hepatic[18] failure service. For the rotation in August 2018, the

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[16] Due to moving back to Maryland before completing the five-year program, some of the requirements were completed through [REDACTED]

[17] Throughout the hearing, the parties referred to the program as [REDACTED] Medical Center and also referred to the specific hospital as [REDACTED] Medical Center. This decision will reflect that use of the term as well. When actions occur at a different hospital or medical center, the specific name for that facility will be used.

[18] This service mainly addresses problems with the liver, pancreas, and gallbladder.

Applicant interacted with three faculty members, one fellow, and a junior resident. There were no medical students on this rotation.

7. During July and August 2018, the Applicant had no assigned mentor.

8. In September and October 2018, the Applicant remained at [redacted] Medical Center, but switched to the trauma and acute care surgery service.

9. During the September and October 2018 rotation, the Applicant became a chief resident of the multi trauma unit, the emergency general surgery service, the trauma ICU, and the burn service.[19]

10. During the September and October 2018 rotation, the Applicant had four to six residents below him, as well as three to five medical students.

11. On September 18, 2018, the Applicant met with Dr. Emmett McGuire, Program Director, [redacted] General Surgery Residency Program. At that time, interns had complained of condescending and harsh feedback, as well as crude jokes made by the Applicant.[20]

12. For the month of November 2018, the Applicant had a rotation at [redacted] Hospital ([redacted]).

13. On November 29, 2018, the Applicant met with Dr. McGuire and Dr. Edwards, Program Director at [redacted] Medical Center, to discuss complaints regarding the Applicant's condescending comments, and an incident with an attending physician, Dr. [redacted].[21]

[19] As the [redacted] Medical Center program was relatively new, it only had one fifth-year resident, and therefore, fourth-year residents, like the Applicant, were chief residents.

[20] The meeting notes do not indicate any exact language used, the date of the comments, or more precise details. See Board Ex. 6.

[21] The meeting notes do not indicate the exact language used in the comments, the date of the comments, or more precise details. However, the reason for the meeting uses the term "condescending comments." See Board Ex. 6.

14. For the month of December 2018, the Applicant was assigned to [redacted] Hospital for a head and neck rotation. The Applicant did not have any teaching responsibilities and did not have any other residents with him during this month.

15. For January and February 2019, the Applicant was back at [redacted]

16. In March 2019, the Applicant was sent to a children's hospital in Spokane Washington for a pediatric surgery rotation.

17. In April 2019, the Applicant was assigned to [redacted] Medical Center.

18. During the first week of April 2019, a third-year medical student, [redacted] [redacted], worked with the Applicant.

19. At some point, [redacted] wrote a letter to the director of the residency program to outline her concerns regarding the Applicant's professionalism. See State Ex. 5, pp. 11-14.

20. The letter describes multiple alleged incidents, including:

- The Applicant making a joke about domestic violence. This occurred in the residence lounge in front of the medical student and other residents;
- The Applicant taking personal phone calls via FaceTime in the resident lounge, when patients were being discussed; and
- The Applicant talking to residents and attending physicians in a disrespectful way.

21. Starting on May 1, 2019, the Applicant was rotated back to [redacted] for the month of May.

22. On May 9, 2019, a remediation meeting was held with the Applicant, Dr. McGuire, and Dr. Glenda Quan, Senior Associate Program Director. From the meeting, the Applicant, Dr. McGuire, and Dr. Quan agreed on a remediation plan for the Applicant to: meet with the program director and associate program director monthly, meet with his mentor, and referral to the CPHP.[22] In addition, it was recommended that the Applicant participate in a

[22] Colorado Physician Health Program.

follow up meeting with Dr. Butler, Chief Medical Officer, and read a book, Emotional Intelligence.

23. On May 16, 2019, two letters were issued: one outlining the Applicant's behavior and addressing it to management and the other to the Applicant. State Ex. 3, pp. 6-9.[23] In the letter to the Applicant, the residents specifically wrote, "These concerns have been raised to your attention so that, in concordance with your request at the onset of your remediation period, you may have the opportunity to mitigate your behavior." State Ex. 3, p. 8.

24. On May 16, 2019, the Applicant was suspended from the [redacted] Medical Center, pending an investigation.

25. On May 28, 2019, the [redacted] Medical Center dismissed the Applicant from its General Surgery Residency. Its stated reasons were: professional incompetence; serious neglect of duty or violation of hospital or program rules, regulations, policies or procedures; and action or inaction reasonably determined by the hospital to involve moral turpitude or that is contrary to the interests of patient care or the hospital. State Ex. 3, p.2.

26. The Applicant applied for an initial medical license on August 8, 2019.

27. On the Application, the Applicant answered yes to the following questions:

- 16e – Has a hospital, related health care facility, HMO, or alternative health care system ever investigated you or ever brought charges against you?
- 16f – Has a hospital, related health care facility, HMO, or alternative health care system ever denied your application; failed to renew your privileges, including your privileges as a resident; or limited, restricted, suspended, or revoked your privileges in any way?

[23] The letters are attributed to the residents at [redacted] Medical Center. However, the record was unclear if all of the names listed were residents or if any were medical students, and whether the names listed were a complete list of residents at [redacted] Medical Center at the time. As none of the residents were called as witnesses at the hearing, only their last names will be referenced herein. The residents that signed the letter were: [redacted]

- 16g – Have you ever pleaded guilty or nolo contendere to any criminal charge, been convicted of a crime, or received probation before judgment because of a criminal charge?

- 16h – Have you ever committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgment? Such offenses include, but are not limited to, driving while under the influence of alcohol or controlled dangerous substances.

- 16n – Has your employment or contractual relationship with any hospital, HMO, other health care facility, health care provider, institution, armed services, or the Veterans Administration ever been terminated for disciplinary reasons?

28. On the Application, the Applicant answered no to the following questions, but provided explanations:

- 16b – Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services, or the Veterans Administration, ever taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment or reprimand, suspension, probation or revocation?

- 16c – Has any licensing or disciplinary board in any jurisdiction (including Maryland), a comparable body in the armed services, or the Veterans Administration, ever filed any complaints or charges against you or investigated you for any reason?

29. The Applicant disclosed the dismissal from [redacted] Medical Center on his application.

30. The Applicant disclosed his arrest and the disposition on his application.

31. On September 4, 2019, the Applicant returned to the [redacted] [redacted] for an initial consultation. This consultation included a comprehensive, multi-dimensional clinical interview and assessment.

32. On May 9, 2020, the Applicant completed a course titled: Addressing Disruptive Physician Behavior. App. Ex. 28A.

33. On May 10, 2020, the Applicant completed a course titled: Risk Management Consult: Managing Disruptive Physician Behavior. App. Ex. 28A.

34. As of July 2020, the Applicant was attending weekly individual psychotherapy to explore the impact of early life experiences, as well as regular and ongoing 12-step recovery meetings, and maintaining consistent contact with his sponsor.

35. As of July 22, 2020, the [redacted] recommended that if the Applicant receive a license, the Applicant continue to follow ongoing regular individual psychotherapy, 12-step recovery meetings, consistent contact with his sponsor, vocational monitoring, and minimum monthly face to face meetings with the clinical staff. Additionally, the [redacted] recommended a board approved ethics and medical professionalism course to follow up with his distressed physicians group.

36. Starting in January 2021, the Applicant began a Program for Distressed Physicians through [redacted] University Medical Center, Center for Professionalism Health. The program includes a three-day professional development course (January 27-29, 2021), as well as three follow up sessions (March 1, April 19 and July 19, 2021). The program also involves assessments at different intervals. The program was ongoing at the time of the hearing, but as of April 29, 2021, the Applicant had participated fully in all assignments and discussions. App. Ex. 28B.

37. The Applicant attended Continuing Medical Education courses in 2019, 2020 and 2021. App. Ex. 28C and D.

38. The Applicant has continued to attend therapy sessions, meet with his sponsor and attend Alcoholics Anonymous meetings to the date of the hearing.

DISCUSSION

Legal Framework

Section 14-205(b)(3) of the Health Occupations Article provides:

> (3) Subject to the Administrative Procedure Act and the hearing provisions of §14-405 of this title, a disciplinary panel may deny a license to an applicant or, if

an applicant has failed to renew the applicant's license, refuse to renew or reinstate an applicant's license for:

(i) any of the reasons that are grounds for action under §14-404 of this title . . . .

Health Occ. § 14-205(b)(3) (2014 & Supp. 2020). The grounds for action under section 14-404 are:

(a) 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:

. . . .

(ii) Unprofessional conduct in the practice of medicine . . . .

Section 14-307(b) of the Health Occupations Article provides an applicant "shall be of good moral character."

The burden of proof in this case is initially on the Applicant to establish that he meets all of the licensure requirements of the Medical Practices Act. *Id.* §§ 14-101 *et seq.* (2014 & Supp. 2020). If the State determines that the Applicant has not satisfied all of the requirements, as it has done in this case by claiming that he is guilty of unprofessional conduct in the practice of medicine, then the burden shifts to the State to establish *prima facie* evidence of that fact. If the State is able to establish *prima facie* evidence of the fact, then the burden shifts again to the Applicant to establish the disqualifying fact is not true or not significant enough to deny the Applicant a medical license.

In this case, the Applicant argues that he has satisfied all of the requirements for licensure *but for* the allegation of unprofessional conduct in the practice of medicine. The Applicant further argues that the State has failed to establish a *prima facie* case of unprofessional conduct

in the practice of medicine or, alternatively, that the allegations are not significant enough to deny the Applicant a medical license.

The State's case relies primarily on the hearsay testimony of witnesses who prepared a statement regarding various actions of the Applicant. None of the individuals involved in preparing that statement, nor any individual who directly witnessed any of the alleged actions by the Applicant testified at the hearing. Similarly, none of those individuals provided any statement (oral or written) under the penalty of perjury. It is fundamental in administrative law that hearsay evidence is not inadmissible and may even be the sole basis of the decision. Maryland's APA provides that "probative evidence that reasonable and prudent individuals commonly accept in the conduct of their affairs" may be admitted in a contested case hearing. Md. Code Ann., State Gov't § 10-213(b) (2014); *see also* COMAR 28.02.01.21B (At an administrative hearing, an administrative law judge "may admit evidence that reasonable and prudent individuals commonly accept in the conduct of their affairs, and give probative effect to that evidence."); COMAR 28.02.01.21C ("Evidence may not be excluded solely on the basis that it is hearsay.").

However, "while administrative agencies are not constrained by technical rules of evidence, they must observe basic rules of fairness . . . so as to comport with the requirements of procedural due process afforded by the Fourteenth Amendment." *Travers v. Balt. Police Dep't*, 115 Md. App. 395, 411 (1997). Moreover, "a decision based on hearsay will be closely scrutinized to determine if the decision is supported by substantial evidence." Arnold Rochvarg, *Principles and Practice of Maryland Administrative Law* § 6.11, at 84 (2011).

Maryland's appellate courts "have developed guidelines to assure that the [hearsay] evidence which is credited is *reliable* and competent." *Kade v. Charles H. Hickey Sch.*, 80 Md. App. 721, 727 (1989) (emphasis added). *Travers* is the "most useful Maryland case on hearsay

and administrative adjudications." Rochvarg, *supra*, § 6.11, at 84. In *Travers*, the court emphasized that the "nature of the hearsay evidence" was an important consideration in its "reliability and probative value." 115 Md. App. at 413. The *Travers* court reviewed Supreme Court cases, including *Perales*, and Maryland appellate cases and concluded that "[s]tatements that are (1) sworn under oath, (2) made close in time to the incident, or (3) corroborated are presumed to be more reliable than other statements." *Prince George's Cty. v. Hartley*, 150 Md. App. 581, 596 (2003) (citing *Travers*, 115 Md. App. at 411).

The Positions of the Parties

The issue in this case is whether the Board erred in denying the Applicant's application for a license to practice medicine. The facts are quite clear that the Applicant has satisfied all of the general requirements for licensure; however, the Board, in its Notice of Intent to Deny Reinstatement of Licensee Under the Maryland Medical Practice Act, refused to issue his license because he was found by the Board to be guilty of unprofessional conduct in the practice of medicine and he lacked good moral character. The foundation for those findings is various interactions that the Applicant had with other individuals during his residency through [redacted] Medical Center.

The parties had an opportunity to present evidence at a hearing on the merits to determine whether the Board erred in not granting the Applicant a license to practice medicine based on its determination of unprofessional conduct in the practice of medicine. The evidentiary portion of this case included the testimony of eight witnesses. The Applicant testified on his own behalf and also presented the testimony of the following witnesses: Dr. Gerald Hayward; Dr. Roy Edwards; Dr. Isabel Audet; Dr. Andrew Demeusy; Dr. James Cusack; and [redacted]

The State called only one witness, but, as stated above, relied heavily on written statements.

Letters from the Medical Student and Residents

While neither the medical student, [redacted] nor the residents that signed the letter from May 16, 2019 testified at the hearing, much of the hearing focused on the allegations contained within their letters.

[redacted] wrote a four-page letter addressing her "concerns . . . regarding the professionalism and conduct" of the Applicant. State Ex. 5, p. 11-14.[24] The first incident described the Applicant making jokes after treating a patient for serious injuries incurred from domestic violence. The comments included "At least [redacted] knows what happens when she doesn't listen to a man . . . What, too soon?". *Id.* at 11.

[redacted]'s letter then describes personal video phone calls between the Applicant and his wife in the resident lounge. The letter alleges that the camera was facing the room, and filming while patient names, medical problems, and other information were clearly discussed and audible.

[redacted] described specific interactions between the Applicant and others, including Dr. Streeter, Dr. Quan, Dr. Reynolds, and Dr. [redacted] [redacted] felt the interaction with Dr. Streeter was not respectful and that the Applicant seemed malicious as the day progressed. *Id.* at 12-13. For the interaction with Dr. Quan and Dr. Reynolds, the Applicant knew about a patient returning to the hospital and the other two doctors did not. When he was asked how he knew, [redacted] quoted the Applicant as saying, "Probably the same way that I know the names of my patients and you don't." *Id.* at 13. For the interaction with Dr. [redacted] the Applicant scolded Dr. [redacted] in front of several people. The Applicant allegedly accused Dr. [redacted] of

[24] This letter discusses some patient care concerns; however, when [redacted] Medical Center followed up on this letter, they decided to disregard a medical student's opinion on a fourth-year resident's patient care, and did not follow up any more on her allegations. Similarly, the Board in its denial stated its grounds were unprofessional conduct in the practice of medicine, and a lack of good moral character. The grounds did not raise any issues regarding patient care. Therefore, during the hearing, the allegations regarding patient care were irrelevant.

defying specific instructions that [redacted] contends were not given. [redacted] describes this interaction as incredibly condescending, humiliating, and inappropriate. *Id.* at 13.

[redacted] also complained about personal interactions between herself and the Applicant. She felt he belittled her in front of other residents for asking questions, and expected her to know everything about a patient before she talked to the patient.

The May 16, 2019 letter appears to be from the residents to the leadership at [redacted] Medical Center. However, there are no signatures on that letter, or specific explanation as to who drafted it. The letter states "The purpose of this document is to lay out the collective concerns, as evidenced by a selection of specific examples, held by the General Surgery residents at [redacted] Medical Center regarding the poor conduct and lack of professionalism of our co-resident, [the Applicant]." State Ex. 3, p. 6. There are four categories of concerns listed in the document: sexual harassment, racial insensitivity, unprofessional/verbal abuse, and unsafe patient care.[25]

Under the sexual harassment section, there are two incidents described. In one, the Applicant mimicked the act of fellatio on a water bottle in front of residents and students. *Id.* at 6. The other incident involved a statement made to a gay male resident. Allegedly the other resident indicated he ate a protein bar for lunch, and the Applicant responded, "What's his name?" *Id.* at 6.

Under the racial insensitivity section, there is a single incident referenced. In that incident the Applicant allegedly told a resident of Mexican nationality that the Applicant was ". . . going to go on a safari to Mexico to hunt your people." *Id.* at 6.

[25] While this document references patient care, as stated above, the Board did not list patient care as a ground for the denial of the license, and no expert testified at the hearing regarding the appropriateness of any care provided by the Applicant.

Under the unprofessional and verbal abuse section, there are four different incidents. The first involved comments after treating a female trauma patient who was the victim of domestic violence. The Applicant allegedly stated, "This is why she should have stayed in the kitchen," as well as telling a medical student that the medical student "knows not to talk back if she wants to keep her spleen." *Id.* at 6. In this section, the writers assert that the Applicant and his wife had video calls while patient care discussions were occurring, and sometimes inappropriate sexual comments were made during those calls. The third allegation is that the Applicant called the nurses "the help." The fourth allegation in this section included specific incidents of degrading and derogatory language to junior medical residents and medical students. The language is quoted in the letter as:

- "Shut the fuck up, you are an intern. You don't speak to anyone, just keep your head down and do your job."
- "You don't ask questions in the middle of didactics unless you are told that you can speak."
- "You will not speak to attendings directly; you will keep your mouth shut finish rounds, and do what I tell you to do."

Id. at 6.

The letter describes the Applicant's demeanor as toxic to the program. The letter requests that the "appropriate corrective action" be taken in an expedient time period. *Id.* at 7.

Testimony of the Applicant

The Applicant testified extensively during the hearing. He discussed his childhood and the difficult family dynamic. His father was an abusive alcoholic, and his mother was abusive. The abuse was both verbal and physical. He discussed his parent's divorce, financial issues of

the family, and lack of basic necessities. By middle school, the Applicant stopped seeing his father. During his junior year in high school, the Applicant started sleeping in his car.

Despite the tumultuous home life, the Applicant did well academically in high school. He then continued his academic pursuits at Johns Hopkins (2001 – 2006). The Applicant had a combined undergraduate and master's program. His family did not financially support his education. During his time at Johns Hopkins, the Applicant was on the rugby team and a varsity track athlete. The Applicant lived on campus for freshman and sophomore year (as it is part of the tuition). However, in junior year, there was a period where he could not afford housing and had to live in his van.

In 2008, the Applicant began medical school at the New Jersey Medical School. During that time, he was involved in a student run Health Care Clinic, was president of the Surgical Society, was the research liaison for the orthopedic surgery society, and published in national journals. He completed medical school in 2012.[26]

The Applicant has worked in various industries and jobs from when he was fourteen years old until 2019 when his residency at [redacted] Hospital was terminated. Prior to starting medical school, he owned a lawn and garden business, a snow removal business, and then worked as a busboy, a food runner, an expediter in a restaurant, and even worked in construction and on a yacht. During medical school, the Applicant worked a part time job with Kaplan[27] teaching Medical College Admission Test preparation, as well as bartending at local businesses.

The Applicant admitted that because of his history he sometimes had used alcohol to numb the pain. In October or November of 2011, the Applicant received a driving under the

[26] Applicant's Exhibit 5 is a Letter of recommendation from the New Jersey Medical School Dean of Students, Dr. Hill. Applicant's Exhibits 6 and 7 are letters of recommendation from other faculty involved with the medical school.

[27] Dr. Mark Hill worked with the Applicant at Kaplan and wrote a letter of recommendation at Applicant's Exhibit 9.

influence (DUI) citation. After that incident, the Applicant described being demoralized and needing to take a strong look at his life. He reported the incident to the medical school, and it was also reported on his Application for license. State Exs. 2 and 7. As a result of this incident, the Applicant entered a program with the New Jersey Physicians Assistance Program (NJPAP). He agreed to a five-year period with counseling and routine urine monitoring from 2012 to 2017.[28]

When the Applicant graduated medical school, he began an orthopedic surgery residency at [redacted] Medical Center in New Jersey. He had disclosed his DUI, and his involvement with the NJPAP. [redacted] Medical Center allowed him to start, but by July 2012, the Applicant left the residency after approximately one month.[29] From July 2012 until the fall of 2014, the Applicant was not in any medical training program. The Applicant continued to work with Kaplan and became the Medical Academics Assistant Director.

The Applicant participated in the [redacted] residency program from July 2014 through June 2015. When he came to Maryland for that program, he worked with the NJPAP to transfer the program to [redacted] and specifically the [redacted][30] The year with the [redacted] program went well from the Applicant's perspective.[31]

After the [redacted] program, the Applicant transferred to [redacted] residency program. During his time at [redacted] the Applicant had communication problems[32] with other residents in the program. The Applicant described some jealousy and resentment

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[28] There is no evidence that the Applicant's DUI impacted any patient care. Similarly, there is no evidence that the Applicant was ever intoxicated in any clinical setting.

[29] Applicant's Exhibit 2 is a letter from Dr. Chalnick, an orthopedic sports medicine and joint replacement surgeon at [redacted] Medical Center.

[30] [redacted] is the statewide professional association for licensed medical doctors and doctors of osteopathy.

[31] Applicant's Exhibit 10 is a letter of recommendation from Dr. Stephen Kavic, the Program Director of the [redacted] program. Applicant's Exhibits 11, 12, and 16 are letters of recommendation from other doctors related to the [redacted] program.

[32] The record lacked details about any specific interaction during this time, but the Applicant generally was described as overly abrupt, critical, and, at times, condescending in his communication with junior residents.

from other residents. Further, the transition was difficult because the [redacted] environment was academic and positive, but the [redacted] environment was not. At [redacted], the Applicant admits to being unapologetically blunt at times. He understands it was not necessarily the content of his statements, but the manner of delivery. He accepted mentorship from Drs. Hayward, Grace, and Hamdallah. While at [redacted] the department issued an administrative suspension[33] that started prior to a holiday period and ended after that holiday.[34] The Applicant contends that his communication improved during the remainder at his time at [redacted] due to this mentorship.[35]

In addition to the mentorship offered through the residency program, the Applicant was still involved with [redacted] for counseling regarding his sobriety. While at [redacted], the Applicant strengthened a number of friendships and created sounding boards. He had professional mentors, plus he had the [redacted] for support. He had stayed active in that program after his five-year commitment ended in 2017. In addition, he continued to attend Alcoholics Anonymous meetings.[36]

During the [redacted] residency program, the Applicant met his wife in 2016, and became engaged in March 2018. They were married in September 2018 (after the Applicant started at [redacted] Medical Center). His wife was unable to relocate to Colorado during his residency at [redacted] Medical Center.

Between July 2018 and May 2019, the Applicant worked at different hospitals as part of his residency program for [redacted] Medical Center. For several of the months, the Applicant had

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[33] This suspension was not reported to a higher level of the institution. It did not impact the Applicant's privileges at the institution, and it did not get reported to the state licensing authority or the national practitioner data bank.
[34] The record was unclear as to what holiday, but indicated the suspension was in December 2017 – early January 2018.
[35] The Applicant provided letters of recommendation from several doctors involved with the [redacted] program, including Dr. Hayward (App. Exs. 13 and 14), Dr. Zatina (App. Ex. 15), and Dr. Grace (App. Ex. 25). In addition, a professional mentor report was provided from Dr. Hamdallah (App. Ex. 17). Part of the [redacted] Residency included a period at a shock trauma rotation, and the evaluation from that period is Applicant's Exhibit 45.
[36] Letters from the Applicant's Alcoholics Anonymous sponsors are located at App. Ex. 37.

little to no teaching responsibilities and worked largely with only the attending physicians and their staffs or limited numbers of residents or fellows. Specifically, the assignments at [redacted] Medical Center (July 2018), [redacted] Medical Center – subspecialty hepatic failure service (August 2018), [redacted] (November 2018, January, February, and May 2019), and Spokane, Washington (March 2019) had no significant teaching responsibilities.

When the Applicant was assigned to [redacted] Medical Center (September and October 2018 and April 2019), however, things were different. The Applicant was a chief resident of the multi trauma unit, the emergency general surgery service, the trauma ICU, and the burn service. The Applicant had four to six residents below him, as well as three to five medical students. The patient list would be approximately eighty to one hundred and twenty patients (as compared to fifteen to twenty patients at [redacted]).

Initially when the Applicant arrived in Colorado, he did not have much support, as his mentors were in Maryland, and his wife and stepson could not relocate to Colorado. He had some communication issues during September through November 2018. State Ex. 6. However, while there, he established a home group in Alcoholics Anonymous, Dr. Edwards was assigned to be his mentor, and Dr. Audet was a second mentor. He also found his way to the YMCA for personal maintenance. He felt that he was settling into life in Colorado. Unfortunately, when the Applicant returned to [redacted] Medical Center in April 2019, he admits that he relapsed into poor communication habits.[37]

On May 9, 2019, a remediation meeting was held to discuss the professionalism issues. The stated purpose of the remediation was to help correct the deficiencies to allow the Applicant to grow and develop into a competent, professional, and successful surgeon. The Applicant understood the remediation to be part of enhanced education and not to be discipline. The

[37] During the hearing, it was clarified that his relapse has no relationship to the Applicant's continued sobriety and only was regarding his communication issues.

Applicant testified that the remediation program required the Applicant to meet with the program director or assistant program director monthly, meet with his mentor (Dr. Edwards), and a referral to the Colorado Physicians Health Program.[38] In addition, it was recommended that the Applicant read the book, Emotional Intelligence, and meet with Dr. Butler, the Chief Medical Officer. The Applicant agreed to the requested remediation program.

After the remediation meeting, the Applicant returned to Maryland for Mother's Day and also for interviews. On May 10, 2019, Dr. McGuire wrote a letter of recommendation for a surgical critical care fellowship.[39] The Applicant returned to Colorado on May 15, 2019. On May 16, 2019, the Applicant was called into the office with Dr. McGuire, Dr. Quan, and three other residents. The Applicant testified that he was told morale was low, that there would be a meeting of residents, and that he should take the afternoon off.

From May 16, 2019, through May 28, 2019, the Applicant was suspended from the program, and on May 28, 2019, he was terminated from the program. Once he was terminated from the program, he informed the medical board that he should be placed on expired status due to no longer being associated with a residency program. The Applicant is not aware of any report to the Colorado Board of Physicians regarding any unprofessional conduct from his time in the [redacted] Medical Center residency program. App. Ex. 41. The Applicant is not aware of any actions being reported to the National Practitioner Databank. App. Ex. 39.

The Applicant submitted his aggregate evaluation reports by the Faculty of [redacted] Medical Center in both July 2019 and January 2019. App. Ex. 29. There were nine faculty members that participated in the evaluation. The comments on this report could be from either the mid-year report or the end of the year report. In terms of verbal comments that the Applicant received from his attendings at the end of the year, the Applicant testified these were positive in

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[38] Applicant's Exhibit 32 is a report from [redacted] Psy. D., from the Colorado Physicians Health Program.
[39] Applicant's Exhibit 18 is the May 10, 2019 letter of recommendation from Dr. McGuire.

respect to levels of professionalism. The evaluation reports indicate that the Applicant had responded to criticisms and had improved. Overall, he obtained a rating of 8.42 out of 10. This was an improvement from his mid-year rating of 7.65. There is nothing in the aggregate evaluation reports that indicated the Applicant lacked good moral character, or should be disciplined or removed from the program.

After being terminated from the residency with [redacted] Medical Center, the Applicant reached out to [redacted] with the [redacted] and set up an intake with that program. From August 2019 to the present, the Applicant has continued regular appointments with individuals from the [redacted] App. Exs. 35-36. As part of the [redacted] program, the Applicant was referred to a group therapy program, advancing emotional intelligence, which he attended from October 2 to December 11, 2019. App. Ex. 33. This group program worked to refine communication skills, learn appropriate ways to offer feedback, increase awareness of your feelings, and consciously decide productive ways to communicate.

Since termination from the [redacted] Medical Center, the Applicant has not worked as a medical professional. Instead, the Applicant has taught at Johns Hopkins University as the lead section instructor of the medical school intensive program for the summer of 2020. He also has become certified as an advanced trauma life support instructor for the University of Maryland. This is taught to residents, existing physicians, physician assistants, nurse practitioners, nurses and others. He has also attended multiple courses, including courses on Managing Disruptive Physicians' Behavior, and Program for Distressed Physicians, as well as continuing medical education courses. App. Ex. 28A-D.

The Applicant could not recall if he used the exact language quoted in the letter, but he did not deny that his communication could be harsh, brash, or insensitive. The Applicant explained some of the comments as poor attempts at humor, where he crossed the line. The

Applicant described his comments referenced in the letter from the other residents as mistakes. He stated that he wished he could take those things back, as those comments have "absolutely no place in the workplace." Applicant's Testimony,[40] T. 487:19-20. The Applicant has faith that this conduct will never recur. The Applicant testified that most of the comments occurred in the September or October 2018 time frame. However, the comments regarding domestic violence were in April 2019. The Applicant testified credibly that his reaction to the domestic violence patient occurred with the mindset of what he grew up with, and with the comments his father made after the abuse the Applicant witnessed. He described horror, and pain, and the triggers the incident raised.

Much of the State's allegations regarding the statements of the Applicant came from a letter from a medical student, [redacted] State's Ex. 5. [redacted] was not called to testify by any party. [redacted] worked at [redacted] Medical Center for approximately a month in April 2019. She worked directly with the Applicant for the first week of that month, as she was assigned other services in the other weeks. The Applicant denies that [redacted] was present during the March 31 conversation regarding the domestic violence patient. The Applicant admits being harsh in his communication with [redacted] that first week of April, but does not recall any intent to belittle her.

The Applicant went on to explain his experience with the Socratic method throughout his medical education, and to him, while it may be embarrassing to not know an answer initially, it was fuel to study, read, and come back with the answer later. The Applicant stated that it is a medical professional's duty to assess their knowledge and to expand it to a level that is professional.

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[40] References to the testimony of witnesses at the hearing will reference page and line of the final transcript.

While the Applicant admits to calling his wife and step-son via FaceTime in the resident's lounge, the Applicant denies making any inappropriate sexual comments to his wife via FaceTime. The Applicant states that the FaceTime communication with his wife and step-son occurred in the resident lounge, not the open floor and not in a manner that violated patient confidentiality.

The Applicant described a slow process of improvement regarding his communication issues. He regrets some of the things he said. He acknowledges that the statements should not have been part of his vernacular at the workplace. During cross examination, the Applicant was asked if he thought his statements may impact the ability of co-workers to communicate. The Applicant stated that part of the training is to debrief, put personal feelings aside, and communicate for the care of the patient.[41] The Applicant also explained that he realizes his communication is an issue and that he has worked on that issue steadfastly for the past two years to make sure it would not be a problem again. He stated unequivocally that these behaviors will not repeat.

Testimony of Dr. Hayward

Dr. Hayward is a board-certified general surgeon. Dr. Hayward has been teaching at the residency program at [REDACTED] Hospital since 1995. The program graduates about three residents per year and has a total of about twenty residents each year. The general surgery residency program is a five-year program. In addition to the residents, [REDACTED] had some medical students. As residents progress through the program, there is a higher expectation for the more senior residents to teach the medical students and junior residents. However, the

[41] There was no evidence of any direct impact on any patient's care based on any alleged statement of the Applicant, nor was there any testimony that any member of the residency program or the hospital staff stopped communicating with the Applicant due to his comments.

residents are not given any courses on how to teach, and different residents have different teaching skills or lack of teaching skills.

Dr. Hayward met the Applicant during his residency at [redacted] (2015-2018). Dr. Hayward interacted with the Applicant every week during the three years of the residency, and operated with the Applicant approximately 30-60 times. Dr. Hayward felt that the Applicant was better than his peers in terms of clinical judgment, patient interactions, and staff interactions. Dr. Hayward testified that he was an unofficial mentor to the Applicant while he was at [redacted] Dr. Hayward was asked what the Applicant's weakness was and answered "Dealing with others in terms of not tolerating – their (sic) not meeting his expectations. If he has very high expectations of himself and he holds others to that same high expectation and not everybody met his expectations and I think that he let that be known." Testimony Hayward, T. 33:5 to 133:9. Surgery attendings, including Dr. Hayward, and nurses discussed with the Applicant ways to change his criticism of others. By the time of the final milestone report from the [redacted] program, the report noted that the Applicant made significant improvement in this area. Applicant Ex. 43. Dr. Hayward spent significant time describing the Applicant's weakness. Essentially, Dr Hayward contends that [redacted] as a program has problems, and that the Applicant would try to correct them all, which was not only impossible, but frustrating and would lead to anger issues. Dr. Hayward testified that the way to get out of the problem is to recognize that it is not your problem. For example, if the medical students were subpar, then the Applicant should let the people paid by the medical school worry about training them.

Dr. Hayward strongly disagreed with any charge that the Applicant does not have good moral character. Dr. Hayward testified that the Applicant knows right from wrong, and would always help someone who asked. Further, Dr. Hayward testified that he believes the Applicant's actions were mistakes, and not professional misconduct. Dr. Hayward accepts that the Applicant

probably said things that he should not have said, but contends these were mistakes. Dr. Hayward testified that he believes the Applicant is an appropriate candidate for rehabilitation for communication and anger issues. He described that every year at the American College of Surgeons Conference there will be a lecture on disruptive physicians (good surgeons who throw things because they are angry). Those disruptive physicians are put into programs (education, and mentoring) to help manage their anger.

Dr. Hayward is willing to act as a mentor for the Applicant. Dr. Hayward has written multiple letters of recommendation for the Applicant. See Applicant Exs. 13 and 14. He also holds the opinion that the Applicant would "be an asset to the citizens in the state of Maryland, providing them health care that's going to be outstanding, the decisions are going to be sound, the treatment is going to be right . . . He just needed to be able to control his temper when other people aren't doing things right." Testimony of Hayward, T. 151:5-9; 23-25.

Dr. Hayward did not directly observe any of the Applicant's behavior at [REDACTED] Medical Center. When asked if he had an explanation for why the Applicant would regress at [REDACTED] Medical Center, Dr. Hayward could only state that he does not know the support systems at that program, but that he still contends it was an isolated incident and not a sign of repeated pattern of bad character.

Testimony of Dr. Edwards

Dr. Roy Edwards worked at [REDACTED] Hospital training residents between 2018 and 2019. He worked with the Applicant for three or four months as a rotating resident. When the Applicant was on the [REDACTED] rotation, Dr. Edwards and the Applicant had daily interactions. These interactions would happen at all hours of the day and night. The team would have junior residents and medical students assigned to the team. As a team, they would take care

of all emergency, general surgery, and trauma surgery that presented to the emergency department of [redacted]

Dr. Edwards was assigned to be the Applicant's mentor because Dr. Edwards had a rough transition in his early training. Dr. Edwards described his awakening, and testified to the changes that occurred in his career. Dr. Edwards described the amount of responsibility and expectations on a resident. He also described the lack of control, such as being told when to eat, when to be at work, when you can take a break, etc. Dr. Edwards described how that transition to submissiveness caused him to be in a bad mood and hostile to life in general.

Dr. Edwards found the Applicant to be very skilled as a resident. He described the Applicant as in the top ten percent of all residents he has ever trained. Dr. Edwards described the Applicant's clinical decision making as sound, and did not personally observe any abnormal interactions with staff members, nurses, emergency room physicians, or junior residents. In approximately October or November 2018, Dr. Edwards received a report of a heated discussion between the Applicant and a junior resident in front of the nursing station. Based on this report, Dr. Edwards and another doctor, Dr. Audet, counseled the Applicant regarding his temper and acceptable workplace behavior. Dr. Edwards did not receive any other complaints regarding the Applicant (even though Dr. Edwards provided his cell phone number to a doctor and a charge nurse to be able to report complaints at any time). After that counseling, Dr. Edwards received a few positive comments about the Applicant, including from a nurse who discussed the time, patience, and attention the Applicant spent with a patient to calm them down and answer all of the patient's questions, and from a junior resident, who gave the Applicant a hug and thanked him for being a good chief resident when her rotation ended.

Dr. Edwards testified regarding the lack of training in a residency program related to communication, interpersonal skills, and dealing with stressful situations. However, Dr.

Edwards testified that his training program was through the military and may not be the same as a civilian program. Dr. Edwards described the process of residency from an intern to a junior resident to a senior resident to explain the responsibilities and expectations for each level.

Dr. Edwards attended a May 9, 2019 meeting to address complaints about the Applicant. Dr. McGuire and Dr. Quan called the meeting after receiving the complaints regarding the Applicant's behavior. A medical student had written a five-page letter detailing her perception of the Applicant and at the meeting, the Applicant was told he would be placed on probation with possible remediation. The issues addressed at this meeting were not due to patient care.[42]

After a trip to Maryland, the Applicant returned to Colorado on May 15, 2019 and was called to the program director's office on May 16th. On May 16, 2019, the Applicant was suspended from the residency program pending an investigation through Human Resources. There was no investigation through the ACGME.[43] In Dr. Edwards view, an investigation by the ACGME would require lots of evidence and documentation of incompetence before someone is terminated, however, less is required for an human resources investigation. After learning that the Applicant was terminated, Dr. Edwards contacted Dr. McGuire and explained that he disagreed with the termination of the Applicant and that the doctors at [redacted] (Dr. Audet, Dr. Lynn, Dr. Georget, and Dr. Edwards) would be happy to have the Applicant complete his final year of training with them. Dr. Edwards also spoke with the Chief of Surgery and Dr. Cheng, the president of the medical staff, stating that [redacted] would train the Applicant for his last year of training. The request to allow the Applicant to finish his training at [redacted] was denied by Dr. McGuire.

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[42] While the medical student's letter addressed patient care issues, Dr. Quan specifically removed those from the official counseling because the program took the position that it was not appropriate for a medical student to comment on the medical decisions and knowledge of a fourth-year surgery resident.

[43] Accreditation Council for Graduate Medical Education

Dr. Edwards did find that the behavior described by the medical student was unprofessional, but was also of the opinion that you should counsel someone after that letter and see if their conduct is corrected. If the behavior continued, and there were no efforts to improve, then termination would be appropriate.

Dr. Edwards holds the opinion that the Applicant "has proven himself to be competent in patient care, clinical decision making, and operative skills." Testimony of Dr. Edwards, T. 196:11-15. Further Dr. Edwards holds the opinion that the Applicant's professionalism skills have improved over time. Dr. Edwards opined that the Applicant would benefit from ongoing counseling and therapy to assist with communication issues with staff, because the pressures of training as a surgeon are very intense and only relieve slightly when training is finished. Dr. Edwards holds the opinion that the Applicant has the potential to be a successful physician and surgeon in all aspects of the profession, and he would not hesitate in offering him a job. In addition to his testimony, the witness wrote letters of recommendations on September 25, 2019 and February 6, 2020. App. Ex. 19. Dr. Edwards participated in the evaluation of the Applicant for his year at [redacted] Medical Center, and is aware that the Applicant scored 8.42 on a 10-point scale which would fall into an above average range. App. Ex. 29.

Testimony of Dr. Audet

Dr. Isabelle Audet, an acute care/trauma surgeon, described the hierarchy of the residency program. She explained that at each level you are led by a person that is one round above you. Attendings generally do not interact much with the medical students. The younger residents answer to older residents. The younger residents are doing more of the floor work, detail work, or busy work. The more senior residents are in charge of the service, delegating duties, and learning how to operate. A more senior resident would spend most of the time in the operating room and hoping that the junior residents are completing the work on the floor.

Dr. Audet met the Applicant in November 2018 at [redacted] The Applicant was the chief resident at the service and Dr. Audet was on-call. She would take eight to ten days of call a month at [redacted] [redacted] is a small inner-city hospital with a large indigent population. Some of the patients came after their problems had festered for some time, which created complex and complicated operations on very sick patients with a lot of underlying health diseases (such as hypertension or diabetes) that were either not diagnosed or not managed. In addition, the home lives of the patients often were not ideal, which meant longer hospital stays and more planning for transition to discharge.

Dr. Audet described the Applicant as more independent and mature than other residents of his year. He understood the social situations and the ramifications of a patient going home and having a safe area to recover. The Applicant was more knowledgeable and well-read than others at his level. He had amazing technical skills. Dr. Audet stated without hesitation that "[the Applicant is] the only resident in all these years, and even to this day, that I would let operate independently, that I would trust to continue operating while I would go see a trauma. He's really gifted." Testimony of Dr. Audet, T. 230:2-5.

Because [redacted] was a smaller hospital, attendings would spend time all day with the residents. The interactions would start with morning rounds and continue until the residents would leave in the evening. The Applicant chose to spend the night, which was not required of a resident. The Applicant would stay, study, and wait for cases to come in. The Applicant worked with Dr. Audet for four months (November 2018, January, February and May 2019). After her work experiences with the Applicant, Dr. Audet holds the opinion that he possessed good moral character and was able to exercise professional conduct in all of his roles as a fourth-year resident.

Dr. Audet did not personally observe any difficulties or problems between the Applicant and other residents, students, or patients. She never saw any situation where the Applicant's interactions with patients or colleagues presented a risk to patient care. Dr. Audet stated that the Applicant was professional but warm with the patients. Testimony of Dr. Audet, T. 232:24. She testified that the Applicant explained the procedures at length, and instilled a lot of trust in his patients.

Dr. Audet further testified that the Applicant reacted well to criticism. Specifically, she had received complaints from two nurses who indicated the Applicant's style was a little rough and condescending. This occurred in early November 2018. He showed humility and remorse. He took criticism constructively and acted upon it to make changes immediately. After Dr. Edwards spoke to the Applicant, the nurses reported back to Dr. Audet that the Applicant "had done a total 180 and that he was a great team player." Testimony of Dr. Audet, T. 234:21-23. Dr. Audet said that the Applicant became the nurses' favorite resident by the end of November 2018. For the months in 2019, the nurses would be excited when the Applicant was returning because they knew that the patients would be well cared for and their questions would be answered properly. In terms of the interaction between the Applicant and medical students and residents, Dr. Audet testified that the Applicant provided more teaching and more opportunity for the medical students and the residents because he was more comfortable and had better command of the surgical experience than other residents of his year.

When Dr. Audet heard about the May 9, 2019 meeting from Dr. Edwards, she and Dr. Edwards asked if the Applicant could return to [redacted] to finish his residency. She stated that [redacted] had no problems with the Applicant and loved having him on the service because it ran so smoothly and made their jobs easier. According to Dr. Audet, the problems only seemed to have occurred at [redacted] and not at any of the other hospitals that

were part of the residency program. The proposal for the Applicant to return to [redacted] had the support of the trauma director, Levine,[44] the Chief of Staff, Dr. Jonathan Gallen, the Chief Executive Officer, Daphne David, and two other surgeons.

Dr. Audet had worked at both [redacted] Medical Center and [redacted] earlier in her career, and was able to describe the different environments. At [redacted] Medical Center, the hospital was very busy, and so the residents and attendings were farther apart. The residents worked independently for a large amount of the time. Also, all of the didactic teaching was performed at [redacted] Medical Center. [redacted] is a smaller facility, both in size and number of patients. Therefore, the residents and attending would round more frequently and have more interaction with the patients. Dr. Audet heard complaints from several residents over the past few years that the attending doctors at [redacted] Medical Center are not around a lot. They have different cultures.

Dr. Audet also explained that communication issues between senior and junior residents are common in residency training programs. There is a lot of competition and bickering. There is a bit of a power struggle in any residency program but particularly surgical residency where personalities tend to be strong. Informal mentoring and counseling are common to work through these communication issues. This is similar to the counseling that Dr. Edwards and Dr. Audet engaged in November 2018 to help the Applicant work through the concerns of the nursing staff.

Dr. Audet testified that she talked with [redacted] who were all residents that signed the complaint letter concerning the Applicant. She was angry and wanted to know what happened that led to this letter. She talked to the residents individually as

[44] No first name or professional license was provided in evidence for this individual.

they came back on her rotation.[45] Dr. Audet has no personal knowledge of the events described in the letter. All three of them allegedly expressed remorse at signing the letter. They allegedly told Dr. Audet that the program director brought them in and a mob mentality started to form. According to Dr. Audet, the residents told her that the program director suggested writing a letter, and they each felt obligated to sign it because everyone else was signing it. All three indicated that they felt pressure to sign it, but that they never thought it would lead to the Applicant's termination from the program. The other residents expected that the Applicant would have a reprimand or a disciplinary action. ███ had actually given the Applicant a hug in the doctor's lounge and thanked him for being an excellent teacher and having an excellent rotation at the end of February 2019. Two months later, ███ signed the letter with the other residents.

Dr. Audet has stayed in touch with the Applicant since his departure from ███ Medical Center. She still holds the opinion that his moral character and professionalism are outstanding. She also holds the opinion that counseling and therapy could benefit the Applicant in his communication issues with colleagues. She further believes that a vocational mentor would be beneficial to the Applicant. She would hire the Applicant to either finish his residency or as a fully trained general surgeon. She explained that he has an excellent rapport with patients and the staff. He also has outstanding surgical skills and can work independently. She described that many graduating residents still need a lot of monitoring or more operative experience; however, the Applicant could be independent. Finally, she described the Applicant as a really nice guy, and she would get along great with him. In addition to stating these things in her

[45] The remainder of this paragraph is based on the testimony of Dr. Audet. None of these three residents testified during the hearing to provide a direct version of events. During the testimony, Dr. Audet was forthcoming with answers, which appeared unrehearsed and honest. There was nothing in her demeanor that caused me to doubt her testimony.

testimony, Dr. Audet also wrote a letter of recommendation for the Applicant on October 29, 2019. App. Ex. 20.

Testimony of [redacted]

[redacted] is a clinical social worker and psychotherapist. Her specialty is in clinical patient care and she has maintained a private practice since 2012. She was accepted as an expert witness to testify in the field of social work, to provide information concerning the counseling and therapy that she performed, the conclusion she reached, and the opinion she reached during that treatment. The majority of her clients are dealing with trauma or addictions. [redacted] is certified in trauma treatment, and has taken additional trainings in Eye Movement Desensitization and Reprocessing (EMDR),[46] which is an evidenced-based practice that treats trauma. In her graduate work, she took additional classes in addiction, and she interned at the Veterans Administration, Intensive, Addiction Treatment Program. She has treated a variety of professionals, including doctors, nurses, CEOs, lawyers, and firefighters.

[redacted] received a referral from [redacted] at [redacted]. As a result of that referral, the Applicant became [redacted]'s patient. This was [redacted]'s first referral from [redacted] and her first interaction with the Applicant. [redacted] first started seeing the Applicant as a patient on October 15, 2019 and continued to see him through the date of the hearing. The appointments were initially weekly (October 2019 to October 2020), and then

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[46] [redacted] explained EMDR, stating:

> Sure. So this type of treatment was developed by a woman named Francine Shapiro, and she kind of fell upon it accidentally, in following that -- the nystagmus with the eyes created a -- a decrease in symptoms, whether it was anxiety or whatever, so she worked with the -- worked with it further. And so in simple terms, what -- what happens is, with this nystagmus in the eye, it's activating the right and left side of the brain, which then taps into the amygdala where trauma is stored. And then in the process, when you're doing EMDR, you are desensitizing -- you are processing and desensitizing the trauma at the same time, and then thought being -- then we install a more positive schema, and though EMDR has this wonderful way of helping you process through traumatic incidents, but then it also can enhance positive states.

Testimony of [redacted] T. 298:22-299:11.

became twice a month (October 2020 to May 2021). [redacted] provided quarterly reports to [redacted] regarding the treatment of the Applicant. App. Ex. 34.

[redacted] described the Applicant as very upfront in terms of why he was in counseling. He understood the need to address his professionalism, humor, and how he interacted and communicated with people. The Applicant informed [redacted] about his prior addiction to alcohol, and that he had been sober since July 2012. The Applicant described his family and childhood history, including his abuse (which required intervention by the Department of Family and Human Services, and the police). The abuse from his parents included both verbal abuse and manipulation, as well as physical abuse. In addition, the Applicant witnessed domestic violence. To process his trauma from his childhood, [redacted] used EMDR with the Applicant.

Despite his home life, the Applicant was able to maintain very high grades and involvement in sports and extracurricular activities. [redacted] testified that the Applicant was eager to learn about himself. He was honest about his character defects, and according to [redacted] showed growth at every quarterly report. See App. Ex. 34.

According to [redacted] the Applicant had very high expectations starting at a very young age, beyond those of a normal child. So, he learned to be a perfectionist. Similarly, if he observed someone not doing their job correctly, he did not hesitate to call them out. [redacted] explained that when you are a child and being beaten or abused on a regular basis, the trauma is trapped in the nervous system and creates symptoms (such as post-traumatic stress disorder, or anxiety). It becomes engrained and therefore, the same behavior will come out at the workplace or at home. The triggers for the Applicant were perfectionism and making a mistake. He expected perfection from his colleagues, and he would call out his colleagues, sometimes not in a professional manner, when they made mistakes.

[REDACTED] holds the opinion that the Applicant possesses good moral character. The Applicant does not engage in illegal or harmful behavior to others. He is a caring and loving husband and father. He is striving to be the best person he can be. [REDACTED] provided examples of improvements with communication between the Applicant and his wife as well as with his step-son. She also discussed his willingness to apologize to both her and his family when he is wrong.

One of the changes in his communication the Applicant is trying to make has to do with authoritarian versus authoritative communication style. Authoritarian communication is more rigid and harsh. Authoritative is direct, but can include caring and understanding. [REDACTED] believes that the Applicant is making progress in those areas and that he would be able to employ the authoritative, rather than authoritarian, style in the workplace. However, during the Applicant's treatment with [REDACTED] the Applicant did not work as a medical professional.

[REDACTED] holds the opinion that during the process of working with her, the Applicant learned to recognize problems in his past behavior, and now knows how to behave in the present or future. This shows that he has integrated his healing and what he learned about himself and how to interact and behave professionally with others. When asked more specifically about this integration, [REDACTED] described that the Applicant could identify his triggers, verbalize them, acknowledge them when something happens, and step back before acting to make sure to handle the situation professionally. Even with the progress, [REDACTED] believes continued therapy twice a month would be beneficial to the Applicant, with the possibility of increased frequency if a specific trauma issue is raised and needs to be addressed. [REDACTED] believes a vocational mentor would make the Applicant feel more secure, but had no opinion as to the frequency for those mentorship meetings.

As to the inappropriate jokes, [redacted] testified that the Applicant "has stated that no joking, no cursing, no type of racial remarks are accepted at all in the workplace, and he has spoken a lot about how he will -- how he will behave professionally in the future." Testimony of [redacted] T. 298:9 – 12.

Testimony of Dr. Demeusy

Dr. Andrew Demeusy met the Applicant in 2014 as the Applicant interviewed for a position in the [redacted] residency program. Dr. Demeusy was one year ahead of the Applicant in the [redacted] residency program. They were in the residency program together for three years and socialized outside of the program. Dr. Demeusy testified that the Applicant's hand skills are some of the best he has ever seen and the Applicant's medical knowledge was better than his peers.

Dr. Demeusy observed communication between the Applicant and others. When the Applicant was talking to someone above him in the residency program, the Applicant was always very professional. However, when the Applicant was talking to someone at his level, or lower, he would sometimes require colleagues that made a mistake to stay beyond their shift and fix a mistake. Dr. Demeusy further described that the Applicant would sometimes use a tone or language that may be appropriate in a family relationship but not a professional relationship to correct those that made a mistake. This type of correction happened when either the Applicant or the service would look bad due to the mistakes of his colleagues or junior residents.

Dr. Demeusy also described some incidents of the Applicant using humor that fell flat or reading the room incorrectly, and other people did not find it funny. One example was that the Applicant would make jokes about how people received injuries, like saying the patient was in a dog fight. Dr. Demeusy also described that the Applicant saw all the other residents as friends,

and that the environment in a residency is less friendly where people are looking out for themselves and are not necessarily your friend.

Since Dr. Demeusy was with the Applicant for most of the day, he was asked by Dr. Hayward and Dr. Grace to work with the Applicant as things happened and to provide mentorship and feedback at the time of an incident. For approximately six months prior to the Applicant leaving the [redacted] program, Dr. Demeusy testified that there were no further problems occurring. However, later in his testimony, Dr. Demeusy revised to say the incidents were decreasing in frequency and intensity.

Dr. Demeusy and the Applicant remained close personal friends after the Applicant began at [redacted] Medical Center. Dr. Demeusy testified as to the additional stress of the Applicant being so far from his wife and step-son during the [redacted] Medical Center residency. Dr. Demeusy remained a close personal friend of the Applicant when the Applicant returned to Maryland.

Dr. Demeusy described the difference between the Applicant at [redacted] from the Applicant in the present. He testified that there are no excuses now, which was something the Applicant gave at [redacted] The Applicant has an awareness of what he could have controlled or changed to affect outcomes, and Dr. Demeusy testified this is different than before. Dr. Demeusy holds the opinion that the Applicant has good moral character, and would be a competent and capable physician. Dr. Demeusy testified that he would love to have the Applicant join the practice. Dr. Demeusy holds the opinion that the Applicant would benefit from ongoing therapy and working with a vocational mentor.

Testimony of Dr. Cusack

Dr. Thomas Cusack is a neurointensivist and surgical critical care physician at Washington Hospital Center in Washington D.C. Dr. Cusack met the Applicant while they were

both at Johns Hopkins. Both played rugby on the same team and worked at the same restaurant in Baltimore. Both also attended the New Jersey Medical School from 2008 to 2012. The two stayed in touch while the Applicant was a resident at [redacted] and Dr. Cusack completed his fellowship at Johns Hopkins.

Dr. Cusack testified as to the characteristics of the Applicant as a teammate (reliable, fun, work hard/play hard), and as a co-worker (reliable and hardworking). Dr. Cusack talked about the language used at the restaurant, and described it as crude and full of humor. Dr. Cusack also testified regarding a roughness in the communication learned at the New Jersey Medical School. The style there was hard-charging and aggressive. According to Dr. Cusack, that style does not translate well to other institutions. Dr. Cusack described needing to evolve over his training, to couch criticism, be generous with praise, manage disagreements with other colleagues, and to be careful in how you express disappointment with people who fail to meet your expectations. Dr. Cusack testified that there is a lack in training on leadership and professionalism in medical school, residency, and fellowship training. Instead, doctors must just look at the examples around them and either follow those examples or deviate from those examples.

Dr. Cusack has an opinion that the Applicant is a genuinely good person, and he would allow the Applicant to care for his family members. Dr. Cusack holds the opinion that the Applicant employs professional conduct because he displays good decision making under pressure in the clinical context, and the Applicant is now reflective of his communication, and is aware of the stakes.

Dr. Cusack read the allegations against the Applicant, and admitted that at their worst the comments are horrifying and at their best misunderstood. If he only had that paper to define the Applicant, Dr. Cusack would think he is "an unfunny Staten Island comedian of the late '90s." Testimony of Dr. Cusack, T. 362:18-19. Dr. Cusack described most of the comments in the

charging documents as statements intended as jokes that were unquestionably not likable or funny. He acknowledges that those comments were unprofessional. However, based on his full range of experience with the Applicant, Dr. Cusack contends that the Applicant cares deeply for his patients and their wellbeing, and further, that the statements made by the Applicant should not define him.

Dr. Cusack believes that continued therapy and interaction with a vocational mentor would be beneficial for the Applicant. Dr. Cusack has interacted with the Applicant in a number of different social interactions and has not seen any indication that the Applicant has not continued his sobriety since 2012.

Testimony of Mr. Thomas

Philip Thomas was the only witness who testified on behalf of the State. Mr. Thomas is a licensing analyst with the Maryland Board of Physicians. He has been employed in this position for almost four years and he has processed approximately 250 applications. A licensing analyst evaluates the applications of potential doctors that are looking for employment in the State of Maryland. This includes verifying credentials (education and training), and checking background from the state and federal government, and any prior licenses or licenses from other states. Mr. Thomas was assigned to process the application in this matter in August 2019. The Applicant's application consisted of an application form and a separate sheet to provide additional information for several questions. State Ex. 2 and 7. These documents were provided by the Applicant at the same time, signed August 8, 2019. In the Application there are two versions of page 7 of 9 and two versions of page 8 of 9. State Ex. 2, pp. 8-11. In the initial Application, incomplete versions of page 7 and 8 were submitted. State Ex. 2, pp. 9, 11. The questions left blank had explanations on the separate sheet. State Ex. 7. Mr. Thomas noticed

this error, and requested the Applicant resubmit those two pages, which he did promptly. State Ex. 2, pp. 8, 10.

During his review of the Application, Mr. Thomas contacted [redacted] Medical Center via email. In that email, he requested all of the documentation in regard to the Applicant and his involvement in the institution as a resident. [redacted] Medical Center provided documentation to Mr. Thomas. However, Mr. Thomas testified that he did not receive a human resources file for the Applicant from [redacted] Medical Center. Mr. Thomas's contact at [redacted] Medical Center was Gina Brooks, whom he believed was the assistant director of the residency. He was not in contact with anyone else from [redacted] Medical Center. Once Mr. Thomas received the file from [redacted] Medical Center, he created a memorandum and presented it to the Board. During the review of the Application, Mr. Thomas determined that the Applicant's suspension from [redacted] [redacted] was an administrative suspension.

Mr. Thomas did not speak to any physicians, residents, or the medical student, [redacted] [redacted], from [redacted] Medical Center. Mr. Thomas did not determine what hospital or program rules, regulations, policies or procedures from [redacted] Medical Center were specifically violated by the Applicant. The final evaluation of the Applicant by the [redacted] Health Center indicated that he had improved in professionalism and rated the Applicant as 8.42 out of a 10. Applicant Ex. 29. However, Mr. Thomas did not follow up with anyone at [redacted] Medical Center after reviewing that document to determine why there appeared to be a discrepancy. In the disciplinary corrective action report, [redacted] Medical Center had checked the box that indicated the disciplinary action was for "conduct and behavior". In addition, the further explanation regarding the reason included only behavioral issues. [redacted] Medical Center did not raise any patient care or patient safety issues. Mr. Thomas did not obtain a copy of any of those rules, regulations, policies or procedures.

Mr. Thomas contacted [redacted] to obtain the milestone project reports. Applicant Ex. 43. Mr. Thomas did not testify to any other investigation into the Applicant's time at [redacted]. Mr. Thomas did not speak to any physician at [redacted].

Mr. Thomas did not reach out to the Colorado Board of Physicians, the Colorado Physician's Health Program, or Dr. [redacted] a psychologist associated with that program. Mr. Thomas did not investigate whether the Applicant had maintained sobriety since 2012. There was no request for the Applicant to submit to testing for alcoholism. Mr. Thomas did not attempt to obtain any documents from [redacted] or speak to [redacted] or any other counselors or individuals associated with that program. Mr. Thomas did not make any attempts to determine whether the Applicant engaged in continuing medical education, therapy, or counseling.

Mr. Thomas testified that his job duties do not require him to reach out to witnesses discovered during an initial investigation. He was not in possession of any contact information for individual witnesses.

<u>Analysis</u>

The Board denied the Applicant his initial medical license due to its finding that he was guilty of unprofessional conduct in the practice of medicine and that he lacked good moral character. The Maryland Court of Appeals has addressed the issue of unprofessional conduct in the practice of medicine in a number of cases that have relevance to the instant case.

The issue before me is whether the Applicant was guilty of unprofessional conduct in the practice of medicine. The Court of Appeals ruled in the case of *McDonnell v. Commission on Medical Discipline*, 301 Md. 426 (1984), that the practice of medicine did not include physician misconduct involving a civil malpractice trial in which the physician, Dr. McDonnell, attempted to influence expert witnesses who were scheduled to testify against him in a medical malpractice

trial. More recently, the Court of Appeals, in the case of *Board of Physician Quality Assurance v. Banks*, 354 Md. 59, 71 (1999), held that a physician's sexual harassment of hospital employees occurred in the practice of medicine. The *Banks* court concluded that limiting misconduct to that which is committed in the process of diagnosing, evaluating, examining, or treating a patient would lead to unreasonable results and render the statute inadequate to deal with the many situations that may arise. *Id.* at 73. The *Banks* court looked to determine whether the activity was intertwined with patient care in such a way as to pose a threat to patients or the medical profession.

In the case before me, there can be no dispute that conversations with colleagues, such as junior residents and medical students, both during clinical care and in the resident's lounge, is intertwined with medical care. The Applicant largely does not dispute the alleged statements. He is not sure of the exact verbiage he used but he did not deny that he made statements substantially similar to these statements. He did not call any witness to refute the specifics of the incidents described. However, the Applicant presented numerous witnesses to testify as to his clinical knowledge and competency, and their opinions as to his current moral character, and professionalism and his growth in his communication skills and understanding of himself. The Applicant presented witnesses, who held the opinion that the Applicant would be a good surgeon and that the Applicant could benefit from additional counseling and mentorship. The Applicant, through counsel, raised arguments that his family history, his experience in industries that are not as formal as the medical field (such as restaurants and construction), and his attendance at a medical school in New Jersey, caused the Applicant to have a somewhat skewed perception as to what communication is appropriate in a more professional setting. Further, the Applicant, through counsel, raised the argument that residents are not taught any skills regarding how to communicate and, more specifically, how to teach junior residents and medical students.

Therefore, the Applicant did not have the proper background or training and would have communication issues when teaching and communication with junior residents and students were involved.

The State did not present any testimony that the allegations against the Applicant had any effect on patient care. Further, the grounds for the denial of the Applicant's license did not address patient care. The issue in this case is whether offensive words can rise to the level of unprofessional conduct in the practice of medicine, and if so, does that also or alternatively mean the Applicant lacks good moral character?

Unprofessional conduct is in the practice of medicine when it becomes a threat to the teamwork approach of healthcare, and in particular when it causes co-workers to avoid interacting with the physician at issue. *Banks*, 354 Md. 59, 75 (1999). The types of comments, interactions, and jokes attributed to the Applicant during his residency at [redacted] Medical Center could cause a toxic environment. The Applicant does not deny being overly harsh and critical of junior residents and medical student. Similarly, he does not deny making comments and jokes to residents and medical students that are inappropriate in any workplace. While he does not necessarily remember or admit to the exact language quoted by the medical student, [redacted], or in the letter attributed to the other medical residents at [redacted] Medical Center, he also did not outright deny that he made substantially similar statements. Even if the exact language quoted was not used, the general tone and theme of his comments and jokes are unacceptable in any professional setting.

It is unclear whether the Applicant's comments, interactions, and jokes actually affected the teamwork approach of healthcare at [redacted] Medical Center. None of the medical students, junior residents, or any attending or program director from [redacted] Medical Center testified as to an effect on the teamwork approach at [redacted] Medical Center. On the contrary, the

attending doctors at [redacted] testified that they had an excellent working relationship with the Applicant and would welcome him back. Further, the Applicant provided numerous letters of recommendation from different portions of his medical education and training, which praised his clinical skills and abilities.

Based on the tone and content of the comments and jokes of the Applicant, I find that the Applicant engaged in intimidation and disruptive behavior that could impact the open communication and teamwork approach of health care. Therefore, I find that his behavior at [redacted] Medical Center was unprofessional conduct in the practice of medicine.

The State also asserted that the Applicant failed to show that he possessed good moral character. While both Maryland Code, Health Occupations Article §14-307 and COMAR 10.32.01.03 require an applicant to possess good moral character, no definition for that term is contained in either the statute or the regulations. "Moral" is defined in Merriam-Webster dictionary as "of or relating to principles of right and wrong in behavior." Definition 1(a) of Moral, Merriam-Webster dictionary, https://www.merriam-webster.com/, accessed on July 28, 2021.[47] "Character" is defined as "one of the attributes or features that make up and distinguish an individual." Definition 1(a) of Character, Merriam-Webster dictionary, https://www.merriam-webster.com/, accessed on July 28, 2021. The Applicant presented seven different witnesses who all testified that he is a moral person and a good person. They discussed how he cared about his friends and family, how he knows right from wrong, and they discussed his care of the patients he treats and making sure they receive the best care. These witnesses provided evidence of the good moral character of the Appellant. The State's position was that the comments and jokes of the Appellant showed that the Appellant did not actually have good moral character. I disagree. While the comments themselves were unprofessional, I do not find

[47] The Merriam-Webster dictionary had numerous definitions of both moral and character, but these definitions are most applicable considering the usage of those words in the statute and regulation.

that they rise to the level of showing that the Applicant somehow lacks the ability to tell right from wrong. Therefore, I find that the Applicant has shown that he has the requisite good moral character required of an applicant. Md. Code Ann., Health Gen. Art. §14-307(b) and COMAR 10.32.01.03A.

The Applicant, through counsel provided various prior decisions of the Board in a Memorandum filed on May 21, 2021.[48] The Applicant's position is that if unprofessional conduct in the practice of medicine is found, consideration should be given to the extensive therapy and coursework he has completed to improve his communication. Further, the Applicant's position is that he should not be denied his license, but should have it issued with some protections in place. Namely, the Applicant suggested the following protections: 1) Ongoing therapy with [redacted], with the date that it should cease or decrease left to the discretion of the [redacted] and [redacted] consulting together, with recommendations to the Board and approval from the Board; 2) A vocational mentor who can guide the Applicant and help him; and 3) Reports to the Board on a periodic basis so that the Board knows that there are no workplace issues that are recurring.

While Section 14-204(b)(3)(i) allows for the denial of a license based upon any reason that is a ground for action under Section 14-404 (such as unprofessional conduct in the practice of medicine), it does not require a denial. There is no guidance in the statute as to determining whether a denial of an application should occur in a specific case. I find COMAR 10.32.02.09, Sanctioning and Imposition of Fines, and 10.32.02.10, Sanctioning Guidelines for Physicians,

[48] During the hearing, I granted the parties until May 21, 2021 to provide any binding or persuasive authority in a written memorandum. These memoranda were not required and would be considered as part of the closing argument. The State did not submit a memorandum. Subsequent to the May 21, 2021 submission, on July 1, 2021 and July 26, 2021, the Applicant sent in additional Consent Order cases that were issued after May 21, 2021. The State responded to the July 1, 2021 email by stating that sanctions imposed via consent orders have no bearing on the Board's consideration of circumstances. *Board of Social Workers v. Chertkov*, 121 Md. App. 574, 587 (1998). All of the submissions will be maintained with the record, but will not be official exhibits in this case.

persuasive as to various factors to consider when determining whether or not a license should be denied.

COMAR 10.32.02.09 provides mitigating and aggravating factors to consider. In this matter, the following mitigating factors are present: 1) the Applicant self-reported the incident on his application, 2) the Applicant admitted the misconduct, made a full disclosure, and was cooperative, 3) the Applicant implemented remedial measures to correct or mitigate the harm from the misconduct, and 4) the Applicant has been rehabilitated or exhibits rehabilitative potential. The following aggravating factors are present: 1) the behavior was part of a pattern of detrimental conduct, 2) the Applicant committed a combination of factually discrete offenses adjudicated in a single action, and 3) previous attempts to rehabilitate the Applicant were unsuccessful. Unprofessional conduct of the type that occurred in this case is not listed in the Sanctioning Guidelines for Physicians. COMAR 10.32.02.10. However, other unprofessional conduct has a range of sanctions from at worst a revocation, to at least a reprimand. Considering all of those factors, and the evidence in this case, particularly the amount of rehabilitation that the Applicant has undergone in the past two years, I find that the Board erred in denying the Applicant's application for a medical license.

Instead, I propose that the Board issue the Applicant's license, but place the Applicant under Probation for a minimum period of one year. During probation, the Applicant shall comply with the following terms and conditions of probation:

1. The Applicant shall continue therapy with [redacted] at least two times a month.[49] The frequency of this therapy shall not decrease without written recommendations from the [redacted] and [redacted] and approval from the Board.

2. The Applicant shall obtain a vocational mentor and shall consult with that mentor at least monthly.

[49] The original decision issued August 10, 2021 incorrectly stated that therapy should occur at least two times a week.

3. The Applicant shall fully and timely cooperate with all therapy, treatment, evaluations, and screenings as directed by the [redacted].

4. The Applicant shall sign and update the written release/consent forms requested by the Board and the [redacted], including release and consent forms to authorize the [redacted] to make verbal and written disclosures to the Board and to authorize the Board to disclose relevant information from [redacted] records and files in a public order. The Applicant shall not withdraw his release/consent.

5. Appellant shall furnish reports to the Board on a periodic basis from his therapist and mentor so that the Board knows that there are no workplace issues that are recurring.

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Proposed Findings of Fact and Discussion, I conclude as a matter of law that the Board was incorrect to deny the Applicant a license to practice medicine in the State on the basis that the Applicant lacks good moral character. Md. Code Ann., Health Occ. §14-307(b).

Based on the foregoing Proposed Findings of Fact and Discussion, I conclude as a matter of law that the Applicant is guilty of unprofessional conduct in the practice of medicine. Md. Code Ann., Health Occ. § 14-404(a)(3)(ii) (Supp. 2020); *Bd. of Physician Quality Assurance v. Banks*, 354 Md. 59, 71 (1999). As a result, I conclude that the Applicant is subject to probation of a one-year probation period, with ongoing therapy and mentoring during that period. *Id.* COMAR 10.32.02.09; 10.32.02.10.

PROPOSED DISPOSITION

I PROPOSE that the June 12, 2020, Maryland State Board of Physicians notification to Peter Dixon, M.D., of its intent to deny his application for Initial Medical Licensure be **REVERSED**; and further

I PROPOSE that Peter Dixon M.D. be placed on probation for a one-year period with a requirement to continue therapy and to regularly meet with a vocational mentor.

Signature On File

August 18, 2021
Date Corrected Decision Issued

Erin H. Cancienne
Administrative Law Judge

EHC/da
#193836

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party adversely affected by this proposed decision may file written exceptions with 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 10.32.02.11. Exceptions must be filed within fifteen (15) days of the date of issuance of this proposed order. COMAR 10.32.02.11C(8). The exceptions and request for hearing must be addressed to the Maryland State 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 Board 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 10.32.02.11C. The OAH is not a party to any review process.

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MARYLAND STATE BOARD OF	* BEFORE ERIN H. CANCIENNE,
PHYSICIANS	* AN ADMINISTRATIVE LAW JUDGE
v.	* OF THE MARYLAND OFFICE
PETER DIXON, MD,	* OF ADMINISTRATIVE HEARINGS
APPLICANT	*
LICENSE No.: Unlicensed	* OAH No.: MDH-MBP1-70-20-17967

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CORRECTED PROPOSED DECISION[1]

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

On June 12, 2020, the Maryland State Board of Physicians (Board) notified Peter Dixon, M.D. (Applicant) of its intent to deny his application for Initial Medical Licensure (Application) pursuant to the State law governing the practice of medicine. Md. Code Ann., Health Occ. §§ 14-101 *et seq.* (2014 & Supp. 2020). The Board based its intent to deny the Application on its authority under section 14-205 of the Health Occupations Article; specifically, it found that the Applicant violated sections 14-307 and 14-404 of the Health Occupations Article. *Id.* § 14-205(b)(3)(i) (Supp. 2020); *Id.* § 14-307 (b) (applicant shall be of good moral character); *Id.* § 14-404(a)(3)(ii) (engaging in unprofessional conduct in the practice of medicine).

On August 25, 2020, the Board delegated the matter to the Office of Administrative Hearings (OAH) for a hearing on the Board's intent to deny the Application. The Board further

[1] The Proposed Decision issued on August 10, 2021 contained a clerical error on page 49. The Proposed Decision mistakenly read "The Applicant shall continue therapy with Ms. Armiger at least two times a week." (Emphasis added). The Proposed Decision should have read, "The Applicant shall continue therapy with Ms. Armiger at least two times a month." (Emphasis added). This Corrected Decision is issued to correct that clerical mistake.