IN THE MATTER OF	*	**BEFORE THE**
TIFFANY A. MAPP, D.O.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: H78302	*	**Case Number: 2224-0178 A**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of **TIFFANY A. MAPP, D.O.** (the "Respondent"), License Number H78302, to practice medicine in the State of Maryland.

Panel A takes such action pursuant to its authority under Md. Code Ann., State Gov't § 10-226(c) (2021 Repl. Vol. & 2024 Supp.), concluding that the public health, safety or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

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

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

I. BACKGROUND

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent initially became licensed to practice medicine in Maryland on July 31, 2014, under license number H78302. The Respondent's license is presently active and expires on September 30, 2025.

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

3. Since on or about August 20, 2020, the Respondent has practiced obstetrics at her private medical office (the "Medical Office")[2] in Prince George's County, Maryland.

II. BOARD INVESTIGATION

4. On or about May 10, 2024, the Board received a complaint (the "Complaint") from a physician ("Physician A") at a hospital in Washington, D.C. ("Hospital A"), which alleged that at approximately 9:00 a.m. on May 10, 2024, the Respondent arrived at Hospital A via her personal car with one of her patients ("Patient 2") and a newborn. Physician A alleged that the Respondent may have intentionally delivered Patient 2's baby in her Medical Office earlier that day.

5. Based on the Complaint, the Board initiated an investigation into the Respondent. By letter dated October 4, 2024, the Board provided the Respondent with a copy of the Complaint and requested that the Respondent provide a written response to the allegations. With the letter, the Board enclosed *subpoenas duces tecum* for Patient 2's

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

medical and billing records and for a list of the Respondent's obstetric patients from January 1, 2024 to present with the patient name, date, and location of delivery.

6. On or about October 21, 2024, the Respondent provided the Board with her written response and the requested patient list, which revealed that six of the Respondent's patients ("Patients 1 - 6") delivered babies in the Medical Office since January 1, 2024, including Patient 2.

7. Pursuant to its investigation, the Board obtained the medical and billing records for the five other patients who delivered their babies in the Medical Office. The Board also obtained the medical records for Patient 2 from Hospital B. Additionally, the Board conducted an under-oath interview of the Respondent on November 21, 2024.

III. PEER REVIEW

8. Pursuant to its investigation, the Board referred the medical and billing records and other relevant documents to a peer review entity for review. Two peer reviewers, each board-certified in obstetrics and gynecology, separately reviewed the materials.

9. On or about April 30, 2025, the Board received both of the peer reviewers' completed reports. The peer reviewers independently concurred that the Respondent failed to meet appropriate standards for the delivery of quality medical care for six out of six patients, Patients 1 - 6. The peer reviewers cited the following reasons, among others, for their conclusion that the Respondent did not meet the standards for the delivery of quality medical care:

a. The Respondent regularly plans for and performs obstetric deliveries

in her outpatient Medical Office, even for patients with high-risk pregnancies (Patients 1 - 6);

b. The Respondent actively augments patients to deliver in her outpatient Medical Office without plans for hospital admissions (Patients 1, 5);

c. The Respondent fails to consistently advise patients to go to the nearest hospital when it is clinically indicated, even when there is time for the patient to do so before delivery (Patients 1 - 6);

d. The Respondent fails to conduct fetal tracing, fetal monitoring, or maternal monitoring during the deliveries in her Medical Office (Patients 1 - 6);

e. The Respondent fails to adequately monitor obstetric conditions during delivery at her Medical Office, including Group B streptococcus ("GBS"), anemia, and gestational diabetes (Patients 1, 2, and 6);

f. The Respondent fails to counsel patients on the risks of delivering in the community setting (Patients 1 - 6).

10. The peer reviewers also independently concurred that the Respondent failed to maintain adequate medical records for six out of six patients. In support thereof, the peer reviewers cited the following reasons, among others:

a. The Respondent maintains inconsistent clinical notes. For example, six months after delivery, the Respondent deleted documentation from Patient 1's clinical notes that the Respondent placed a Cook Catheter[3] and administered misoprostol[4] to Patient 1; however, the Respondent's invoice to Patient 1 has a charge for "instrumental cervical dilation" for $245.00 (Patients 1, 5, 6);

b. The Respondent fails to adequately document the monitoring of obstetric conditions during delivery at her Medical Office, including GBS, anemia, and gestational diabetes (Patients 1, 2, and 6);

[3] A Cook catheter is a type of balloon catheter that is used for cervical ripening before labor induction.

[4] Misoprostol is a medication that can be used to induce labor or to manage postpartum bleeding.

c. The Respondent fails to document fetal tracing, fetal monitoring, or labor progress (Patients 1 - 6);

d. The Respondent fails to document maternal monitoring, despite between seven to 13 hours of "face-to-face" time with patients (Patients 1 - 6);

e. The Respondent fails to document her communications with patients before they arrive at her Medical Office, even when they arrive outside of normal business hours at, for example, 2:30 a.m. or 4:45 a.m. (Patients 1 - 6);

f. The Respondent fails to consistently document that she advises patients to go to the hospital and fails to document attempts to transfer patients to the hospital (Patients 1 - 6).

11. On or about April 30, 2025, the Board provided the peer reviewers' reports to the Respondent and gave her an opportunity to review and provide a Supplemental Response to the reports. The Respondent provided her Supplemental Response to the Board on or about May 19, 2025.

12. On or about May 21, 2025, one of the peer reviewers ("Peer Reviewer 2") submitted an addendum (the "Addendum") to her April 30, 2025 report to the Board. In the Addendum, Peer Reviewer 2 stated in part:

a. Outpatient deliveries "carry elevated risks of perinatal death, neonatal seizures, and neurologic dysfunction[;]" however, "[t]here is no documented evidence of patient counseling regarding the increased risks[;]"

b. The "records reveal an absence of recommended additional personnel during deliveries" to address potential complications, and "it remains unclear whether the clinical space is adequately equipped with neonatal resuscitative equipment[;]"

c. The Respondent does not have a "formal transfer agreement" in place with a nearby hospital, which is "essential" for emergency protocol;

d. It is unclear whether the Respondent maintains malpractice insurance coverage for obstetrical services, which is a fundamental requirement for the provision of this care in Maryland;

e. The Respondent's "clinical judgment and professional conduct present a demonstrable risk to the health, safety, and welfare of the public. Accordingly, a summary suspension of [the Respondent's] license is recommended to mitigate any further risk to public safety."

CONCLUSIONS OF LAW

Based upon the foregoing Investigative Findings, Panel A concludes as a matter of law that the public health, safety, or welfare imperatively requires emergency action, pursuant to Md. Code Ann., State Gov't § 10-226(c)(2) (2021 Repl. Vol. & 2024 Supp.) and Md. Code Regs. ("COMAR") 10.32.02.08 B(7).

ORDER

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

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

ORDERED that, during the course of the summary suspension, the Respondent shall not practice medicine in the State of Maryland; and it is further

ORDERED that in accordance with COMAR 10.32.02.08 B(7) and E, a post-deprivation hearing on the summary suspension will be held on **Wednesday, June 11, 2025, at 9:00 a.m.** before Panel A at the Board's offices located at, 4201 Patterson Avenue, Baltimore, Maryland 21215-0095; and it is further

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

ORDERED that a copy of this Order for Summary Suspension shall be filed by Panel A in accordance with Health Occ. § 14-407 (2021 Repl. Vol. & 2024 Supp.); and it is further

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

Signature On File

05/30/2025
Date

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians