IN THE MATTER OF	*	**BEFORE THE**
DAVID A. RODRIGUEZ, D.O.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: H52714	*	**Case Number: 2222-0149A**

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CONSENT ORDER

On September 12, 2023, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **DAVID A. RODRIGUEZ, D.O.** (the "Respondent"), License Number H52714, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. §§ 14-101 *et seq.* (2021 Repl. Vol., 2022 Supp.).

The pertinent provisions of the Act under Health Occ. § 14-404, are as follows:

> (a) *In general.* -- 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; [and/or]
>
> ...
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State[.]

Other pertinent State regulations include:

COMAR 10.32.02.16 Ethics.

The Board and the disciplinary panels may consider the Principles of Ethics of the American Medical Association, but these principles are not binding on the Board or the disciplinary panels.

The pertinent provisions of the Principles of Ethics of the American Medical Association are as follows:

8.5 Disparities in Health Care

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

...

(b) Avoid stereotyping patients[; and]

(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.

FINDINGS OF FACT

Disciplinary Panel A finds the following:

Introduction

1. On or around May 9, 2022, the Respondent prescribed opioid medication to

a patient who had been hospitalized for an overdose approximately two weeks prior. The Board's subsequent investigation revealed multiple violations of the standard of care as determined by appropriate peer review after a review of ten patients treated by the Respondent. Additionally, the Respondent provided an inappropriate course of treatment to a patient based on non-clinical factors such as age, race, and gender.

Licensing Information

2. At all relevant times, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on October 16, 1997, under License Number H52714. The Respondent's license is active through September 30, 2025.

3. The Respondent is board-certified in Physical and Rehabilitation Medicine.

4. At all relevant times, the Respondent practiced at a pain management practice ("the Practice") that has multiple locations in the State of Maryland.

Complaint

5. The Board initiated an investigation of the Respondent after receiving a complaint (the "Complaint") dated May 9, 2022. The Complaint was submitted by a family member of one of the Respondent's patients ("Patient 9") who stated that the Respondent overprescribed opioids to Patient 9. The Respondent was aware that Patient 9 had been hospitalized approximately two weeks prior due to an overdose. As a result, the Respondent agreed not to prescribe Patient 9 any further opioids. However, the Respondent refilled

Patient 9's prescription for oxycodone at Patient 9's request. Thereafter, Patient 9 experienced a relapse.

Respondent's Written Response

6. By letter dated July 25, 2022, the Board notified the Respondent that it had received a complaint alleging that the Respondent overprescribed controlled dangerous substances ("CDS") to Patient 9. The Board provided the Respondent with a copy of the Complaint and requested that he address it in a written response within ten business days. The Board also enclosed a *subpoena duces tecum* ("SDT"), dated July 25, 2022, for ten named patient records, requiring production within ten business days. The letter also directed the Respondent, within ten business days, to provide summaries of the care he provided to the patients whose charts were subpoenaed with corresponding records certification forms.

7. By letter dated August 12, 2022, the Respondent provided a response to the Complaint along with the requested patient records and the respective summaries of care. Patient 9 was present on May 9, 2022, for a procedure and not an office visit. After the procedure was completed, the Respondent was walking out of the doorway when Patient 9 requested a prescription refill. The Respondent entered the prescription order at that time but did not finalize the refill until the end of the day. At the end of the day, the Respondent finalized the patient prescription orders as a batch. The Respondent stated that he checked the Prescription Drug Monitoring Program ("PDMP") system and there was no evidence

of abuse or drug diversion. He also stated that there was no bright yellow warning box displayed in the system indicating a drug related adverse event for Patient 9.

Interview with Respondent

8. On or about November 1, 2022, the Board conducted an interview with the Respondent. During the interview, the Respondent was asked about the incident with Patient 9. The Respondent admitted fault for his mistake. Regarding the incident and Patient 9, the Respondent also stated the following:

(a) "[Patient 9] was a sweet, little old white lady, never came early for medication, never ran out of medication, never looked like a drug abuser, anything like that. So – so typical. So, that sounds almost like profiling. Profiling usually sounds negative. You look at someone – minority, they're – you know, they may look disheveled, dirty, okay. She was quite the opposite; elderly lady, sweet as can be, never came early for medication, never ran out of medications. So, when the family said that she had been admitted, I was in shock. Like, wow."

(b) Patient 9's medication order was listed in the Practice's electronic medical record ("EMR") system amongst orders for other patients. The system allows a physician to approve all of the listed orders with the click of one button. The Respondent did not review Patient 9's medication order before approving all of the orders he had for that day.

(c) The Respondent advised that the Practice's EMR system displays a yellow warning box indicating a drug related adverse event. The Respondent stated the that warning box was in the EMR for Patient 9, however, the Respondent did not see it because he did not look at Patient 9's entire chart at the time that he approved Patient 9's medication order.

Peer review

9. As part of its investigation, the Board referred ten (10) patient records obtained from the Respondent (referenced *infra* as "Patients 1-10")[1] and related materials for peer review. The review was performed by two physicians who are board-certified in Physical and Rehabilitation Medicine. The reviewers submitted reports to the Board which addressed standard of care issues related to the Respondent's treatment of the patients whose charts were the subject of the July 25, 2022 SDT.

10. The reviewers independently concluded that in four of the ten cases reviewed, the Respondent failed to meet appropriate standards for the delivery of quality medical care as follows:

(a) The Respondent inappropriately prescribed high-dose opioid medications in conjunction with benzodiazepines (Patients 4, 5, 8);

(b) The Respondent failed to document a discussion of the risks associated with concurrent use of opioids and benzodiazepines (Patients 4, 5, 8);

[1] To ensure confidentiality and privacy, the names of individuals and entities involved in this case, other than the Respondent, are not disclosed in this Consent Order.

(c) The Respondent failed to adequately prescribe medication intended to reverse an overdose such as Narcan or Naloxone (Patients 4, 5);

(d) The Respondent failed to evaluate the risk of cardiac rhythm complications associated with chronic high-dose methadone use by periodically monitoring electrocardiograms (Patient 4);

(e) The Respondent failed to address inconsistent toxicology results (Patient 4);

(f) The Respondent made little effort at utilizing non-opioid therapies such as physical therapy or occupational therapy to treat chronic pain (Patients 4, 5, 8);

(g) The Respondent failed to properly assess the patient prior to refilling an opioid medication (Patient 9); and

(h) The Respondent failed to consistently taper high-dose opioid regimen to 90 MME/day[2] or less (Patients 8).

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel A concludes as a matter of law that the Respondent is guilty of unprofessional conduct in the practice of medicine, in violation of § 14-404(a)(3)(ii) of the Health Occupations Article; and failing to meet appropriate

[2] MME is an acronym for morphine milligram equivalents. The MME/day metric is often used as a gauge of the overdose potential of the amount of opioid that is being given at a particular time. High-dose opioids are typically defined as morphine equivalent daily doses of 91 or more milligrams. The current CDC Clinical Practice Guideline for Prescribing Opioids for Pain states that dosages of ≥100 MME/day were found to be associated with increased risks for overdose.

standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State, in violation of § 14-404(a)(22).

ORDER

It is thus by a majority of a quorum of Disciplinary Panel A of the Board hereby:

ORDERED that the Respondent is **REPRIMANDED**; and it is further

ORDERED that within **ONE (1) YEAR**, the Respondent shall pay a civil fine of **$5,000.00 (FIVE THOUSAND DOLLARS).** The Payment shall be by money order or bank certified check made payable to the Maryland Board of Physicians and mailed to P.O. Box 37217, Baltimore, Maryland 21297. The Board will not renew or reinstate the Respondent's license if the Respondent fails to timely pay the fine to the Board; and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum of **SIX MONTHS.** During probation, the Respondent shall comply with the following terms and conditions of probation:

Within **SIX (6) MONTHS**, the Respondent is required to take and successfully complete a course on **implicit bias.** The following terms apply:

(a) it is the Respondent's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the courses before the courses are begun;

(b) the Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the courses;

(c) the courses may not be used to fulfill the continuing medical education credits required for license renewal;

(d) the Respondent is responsible for the cost of the course; and it is further

ORDERED that a violation of probation constitutes a violation of the Consent Order;

ORDERED that the Respondent shall not apply for early termination of probation; and it is further

ORDERED that, after the Respondent has complied with all terms and conditions of probation, the Respondent may submit a written petition for termination of probation. The Respondent's probation may be administratively terminated through an order of the disciplinary panel if the Respondent has complied with all probationary terms and conditions and there are no pending complaints relating to the charges; and it is further

ORDERED that the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that, if the Respondent allegedly fails to comply with any term or condition imposed by this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If the disciplinary panel determines 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; and if the disciplinary panel determines there is no genuine dispute as to a material fact, the Respondent 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 the Respondent has failed to comply with any term or condition imposed by this Consent Order, the disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke the Respondent'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 on the Respondent; and it is further

ORDERED that the effective date of the Consent Order is the date the Consent Order is signed by the Executive Director of the Board or her designee. The Executive Director or her designee signs the Consent Order on behalf of the disciplinary panel which has imposed the terms and conditions of this Consent Order; and it is further

ORDERED that this Consent Order is a public document. *See* Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6).

12/20/2023
Date

Signature On File

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

CONSENT

I, David Rodriguez, D.O., acknowledge that I have consulted with counsel before signing this document.

By this Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition.

I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 14-405 and Md. Code Ann., State Gov't §§ 10-201 *et seq.* concerning the pending charges. I waive this right and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive protections. I acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order.

I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.

I sign this Consent Order, without reservation, and fully understand the language and meaning of its terms.

12/14/2023
Date

Signature On File

David Rodriguez, D.O.

NOTARY

STATE OF Maryland

CITY/COUNTY OF Anne Arundel

I HEREBY CERTIFY that on this 14th day of 2023 December 2023, before me, a Notary Public of the State and County aforesaid, personally appeared David Rodriguez, D.O., and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Loni D Graham

Notary Public

My Commission Expires: Dec. 20, 2025