IN THE MATTER OF	*	**BEFORE THE**
ERIC S. FELBER, D.O.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: H70831	*	**Case Number: 2218-0144A**

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FINAL DECISION AND ORDER

INTRODUCTION AND PROCEDURAL HISTORY

On July 24, 2019, Disciplinary Panel A of the Maryland State Board of Physicians ("Board") issued amended charges[1] against Eric S. Felber, D.O. alleging that he violated § 14-404(a)(22) and (40) of the Health Occupations Article, Maryland Code Ann., for failing 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 the state[2] and failing to keep adequate medical records as determined by appropriate peer review.

Dr. Felber owns, and practices at, an urgent care center in Bethesda, Maryland (the "Facility"). After a patient complaint, the Board subpoenaed the complainant's medical records from Dr. Felber and records of ten additional patients of Dr. Felber for review. The Board sent the patient records to a peer review entity and the records were reviewed by two peer reviewers who were board-certified in Family Medicine and who had urgent care experience. Both peer reviewers found that Dr. Felber violated the standard of care in nine of the patient records reviewed

[1] The charges were initially issued on September 24, 2018, but were amended to correct the allegation of fact pertaining to Dr. Felber's board certification in family medicine.

[2] A violation of Health Occ. § 14-404(a)(22) will be referred to as the "standard of care" as it is commonly referred to in the profession.

and found that Dr. Felber failed to keep adequate medical records for all eleven patient records reviewed.[3]

On July 24 and 25, 2019, Dr. Felber received an evidentiary hearing before an Administrative Law Judge ("ALJ") at the Office of Administrative Hearings. At the hearing, the State introduced 27 exhibits, including the eleven patient medical records and the peer review reports. The State also presented testimony from one patient and one of the peer reviewers. Dr. Felber testified on his own behalf and presented testimony from a Board compliance analyst.

The ALJ issued a proposed decision, on October 23, 2019, concluding that Dr. Felber failed to meet the standard of care for eight out of the nine patients at issue (all but patient 7) and failed to keep adequate medical records for ten of the eleven patients at issue (all but Patient 8). The ALJ recommended a sanction of a reprimand and a 6-month probation with probationary terms, including being supervised by a physician supervisor and taking a course in medical recordkeeping.

Exceptions Hearing

On October 25, 2019, the Board sent Dr. Felber a letter explaining the exceptions process, which included the date of the exceptions hearing. The letter stated "[t]he exceptions hearing before Disciplinary Panel B is scheduled for February 26, 2020 at 1:00 p.m. at 4201 Patterson Avenue, Baltimore, Maryland, 21215." The State and Dr. Felber both filed written exceptions. On February 26, 2020, Disciplinary Panel B met to hold the exceptions hearing. The Administrative Prosecutor appeared on behalf of the State. Dr. Felber did not appear at 1:00 p.m. At around 1:45 p.m., Board staff contacted Dr. Felber and asked him whether he was planning on

[3] Dr. Felber was charged with violating the standard of care for Patients 1, 2, 3, 4, 5, 6, 7, 9, and 10, but not charged with a standard of care violation for Patient 8 and 11. For purposes of confidentiality, the Panel redacted the names of Dr. Felber's patients and will refer to them in this Order as Patients 1-11.

appearing at the hearing. Dr. Felber stated that he was not aware of the hearing and asked to reschedule the exceptions hearing. The Panel agreed to reschedule the hearing and sent Dr. Felber a letter, on February 28, 2020, postponing the hearing to March 25, 2020, at 1:00 p.m.

On March 18, 2020, Board staff emailed Dr. Felber a copy of a letter cancelling the hearing because the Board's office was closed to the public due to the Coronavirus pandemic and the Board had not yet developed a procedure for hearing cases remotely. The letter informed Dr. Felber that he would be contacted when the hearing was rescheduled. On March 29, 2020, Dr. Felber sent an email to the Board asking that the charges against him be dismissed.

In an April 16, 2020 letter sent via email and First Class Regular Mail to Dr. Felber, the panel notified Dr. Felber that that the exceptions hearing had been rescheduled for May 27, 2020, at 1:00 p.m., and that the hearing would be conducted by teleconference due to the restrictions on visitors to the Board's offices. Dr. Felber emailed the Board's executive director, on April 17, 2020, stating that he was "invoking his sixth amendment Constitutional right to have a public face-to-face hearing." On April 17, 2020, the Panel sent a letter in response asking Dr. Felber to formally state the basis of his objections. Dr. Felber emailed the Board on April 19, 2020, reiterating his objection to the Panel's teleconference hearing based on sixth amendment grounds and demanded an in-person hearing.

The Panel chair responded and denied Dr. Felber's request for an in-person exceptions hearing. The Panel chair explained in his letter that the sixth amendment applies to criminal, not administrative, proceedings and, therefore, was inapplicable to the exceptions hearing. The letter noted that the scheduled exceptions hearing did not involve witnesses, but, rather, was argument only based on the record established at the Office of Administrative Hearings, and that Dr. Felber had had the opportunity to confront witnesses against him at the evidentiary hearing. It also

explained that Maryland and Supreme Court cases have considered the confrontation clause to be satisfied without face-to-face confrontation when there is a demonstration of necessity. The Panel chair also pointed out that it was necessary to conduct the hearing via teleconference or video-conference due to the COVID-19 pandemic in order to protect the health and safety of the Board members, staff, Dr. Felber and the Administrative Prosecutor. In addition, the letter stated that, pursuant to Md. Code Ann., State Government Article § 10-211(b)(1), a hearing may be held via telephone, video conferencing, or other electronic means unless good cause in opposition is shown. The Panel chair concluded that Dr. Felber did not establish good cause in opposition to holding the hearing by teleconference or videoconference.

On May 22, 2020, the Board sent Dr. Felber an email informing him that the hearing would be held on the Zoom videoconference platform and invited Dr. Felber to participate in a test call of the Zoom platform in advance of his hearing scheduled for May 27, 2020 hearing. The test call was scheduled for May 26, 2020, at 10:00 a.m., and the instructions sent to Dr. Felber included both a link to attending via the Zoom videoconference platform or, in the alternative, a phone number for Dr. Felber to call to conduct the test telephonically. Dr. Felber responded on May 22nd, via email, expressing concerns because he had not used Zoom before. He also claimed the link did not work. Board staff explained that the link was for the test call scheduled for May 26th test and that the link would not work on May 22nd. Board staff also requested that Dr. Felber provide staff with his best contact information. Dr. Felber responded that he was not comfortable using Zoom because of "security issues." Board staff again asked Dr. Felber for a contact phone number. Dr. Felber did not provide a telephone number. Dr. Felber responded that the Board had his telephone number and had called several times. Board staff had earlier that day tried calling Dr. Felber, but the calls did not go through. Board staff explained that his phone number on record

was not working and the Board staff member again asked for his current telephone number so that she could explain the process orally. Dr. Felber did not respond to the email. Later that day, the Board staff member realized that she had transposed the numbers in the phone number she called and she called the correct number and left a message with Dr. Felber's staff and tried calling again at 4:25 p.m., but Dr. Felber's office was closed. The Board staff member then emailed Dr. Felber again and directed him to log in or call in on May 26 at 10:00 a.m. for the test call. Dr. Felber did not respond to the emails or phone messages.

On May 26, 2020, at 10:16 a.m. Board staff emailed Dr. Felber asking him to log in or call in to the Zoom test call. Dr. Felber wrote an email back saying, "I cannot download malware to my computer." Board staff then directed Dr. Felber to use the call-in number from his phone. Dr. Felber did not respond and did not appear for the test call designed to allow participants to familiarize themselves with the Zoom platform or telephone call-in. At 10:40 a.m., Board staff ended the test call due to Dr. Felber's failure to appear. That afternoon, Dr. Felber again sent an email asking for the case to be dismissed. The same day, at 4:58 pm., the Board re-sent the Zoom invitation for the hearing via email, which included a link with instructions for Dr. Felber to log in to the meeting approximately 10 to 15 minutes before his 1:00 p.m. hearing scheduled for the following day, May 27, 2020. In the alternative to Zoom, a telephone call-in number was highlighted as an alternative way to appear at the hearing.

On the day of the hearing, May 27, 2020, at 8:00 a.m., and again, at 12:00 p.m., Board staff emailed Dr. Felber with the links to the hearing via Zoom, and, in the alternative, with a telephone number to call. The telephone number was highlighted in the emails. Board staff also located a personal telephone number for Dr. Felber and called both Dr. Felber's personal telephone number and office telephone number approximately 15 minutes before the scheduled hearing, but Dr.

Felber did not answer his personal telephone number and the office staff stated that he was not in the office. Board staff sent another email at 1:06 p.m. with the email title "Please Call in Now for Your Exceptions Hearing." That email also contained the telephone call-in number. Dr. Felber did not log into the hearing via Zoom or call into the hearing via telephone. At 1:17 p.m. Disciplinary Panel B held the hearing in Dr. Felber's absence and noted that Dr. Felber had been called and emailed multiple times and did not appear. The administrative prosecutor attended and presented the State's case. At 4:53 p.m., Dr. Felber sent the Board an email stating, "My zoom didn't work."

FINDINGS OF FACT

In his written exceptions, Dr. Felber did not take exception to the ALJ's Proposed Findings of Fact. The Panel adopts the ALJ's Proposed Findings of Fact with limited modifications. The ALJ's Proposed Findings of Fact (pages 5-24, numbered paragraphs 1-79, 81-112, 114-153) are incorporated by reference into the body of this document as if set forth in full. *See* attached ALJ Proposed Decision, Exhibit 1. The Findings of Fact were proven by the preponderance of the evidence. The Panel adds a Finding of Fact for Patient 8 that states: For Patient 8's September 10, 2017, visit, Dr. Felber did not record the name, dose, lot number, or expiration date of Patient 8's medication that he administered, nor did he record the location on the body where he administered the injection.

Among other things, Dr. Felber violated the standard of care by conducting insufficient examinations and evaluations and taking inadequate histories. Dr. Felber failed to keep adequate medical records by failing to document adequate examinations, failing to document the area of a patient's injury, failing to document office procedures and failing to document patient history.

DISCUSSION

The Panel adopts the ALJ's conclusions pertaining to Patients 1-7, and 9-11 in full, but does not adopt the ALJ's conclusion that Dr. Felber's recordkeeping pertaining to Patient 8 was not deficient.

State's Exceptions

The State filed exceptions arguing that the ALJ erred in finding that Dr. Felber met the standard of care in his treatment of Patient 7 and erred in finding that Dr. Felber's recordkeeping was adequate for Patient 8. Dr. Felber did not file a response.

Patient 7

Patient 7 saw Dr. Felber, on November 28, 2017, to obtain clearance for a surgery scheduled for November 30, 2017. The Panel adopts the ALJ's Findings of Fact which found that Dr. Felber took vital signs, evaluated allergies, evaluated her current medications, reviewed her past medical history, inquired about whether she had past problems with anesthesia, inquired about her family medical history and ordered lab work. Another physician performed the surgery, as scheduled. The ALJ found that Dr. Felber cleared Patient 7 for surgery.

The State argued that the pre-operative examination was deficient and a violation of the standard of care because his records do not demonstrate that he obtained crucial information through his examination. For example, the examination did not record smoking history, instead listing "no smoking history available for this patient." Instead of listing details under his medical history, the notes just show that Patient 7 "denies" past medical history, ongoing medical problems, family health history and preventative care.

The Panel finds that there is insufficient evidence that Dr. Felber did not meet the standard of care in his treatment of Patient 7. As the ALJ explained, Dr. Felber's role was to determine if

there were any medical contraindications for the surgery. Dr. Felber's records, while brief, included sufficient information for the preoperative consult prior to the surgery. This exception is denied.

Patient 8

On September 10, 2017 and October 21, 2017, Dr. Felber saw Patient 8 and administered a fluphenazine injection to treat her schizophrenia. Dr. Felber did not note that the injections were fluphenazine in the patient's medical record. Dr. Felber's notes also did not list the patients' vital signs. The ALJ, however, found no recordkeeping violation, noting that vital signs were not needed because Patient 8 had not complained of fever or sickness.

The State argued that the medical record should have identified the medication that was injected into Patient 8. The State's expert testified that information about the medication should also include the dosage amount, the lot number, the expiration date, and the location on the body where the medication was injected. The State argues that the ALJ in her own Proposed Decision and Order noted that "documentation must be sufficient in scope, detail and clarity to enable another physician, unfamiliar with the patient, to undertake care of the patient and to understand, from the treating physician's records, the patient's current medical condition, treatment plan and objectives." The State claims that vital signs are also necessary to take and record so that other physicians are aware of the patient's current medical condition and treatment. Dr. Felber did not respond to this exception.

The Panel finds that Dr. Felber should have recorded Patient 8's vital signs regardless of whether the patient felt sick or complained of a fever. More importantly, Dr. Felber failed to include necessary information about the medication he administered, including the name of the medication, the dosage amount, and the location where the medication was injected. The Panel,

therefore, agrees with the State that Dr. Felber failed to keep adequate medical records for Patient 8, in violation of Health Occ. § 14-404(a)(40).

Dr. Felber's Exceptions

Dr. Felber filed a one-page letter of exceptions. In general, Dr. Felber claims that the ALJ erred in concluding that he failed to meet the standard of care. Dr. Felber did not dispute the medical recordkeeping violation. The State filed no response.

Dr. Felber argues that he never had a bad outcome or malpractice lawsuit and pointed out that he has received many positive online reviews. The Panel need not wait for a malpractice lawsuit or patient harm to occur before finding a violation or imposing a sanction. The Court of Special Appeals has held that, unlike malpractice lawsuits, which are tort actions, "[n]o proof of injury or harm is required to take disciplinary actions against a physician's license." *Pickert v. Maryland Bd. of Physicians*, 180 Md. App. 490, 505 (2008). Indeed, the Board's Sanctioning Guidelines anticipate disciplinary actions occurring before harm has occurred, noting as an aggravating factor, that an offense "*has the potential for* or actually did cause patient harm." COMAR 10.32.02.09B(6)(c) (emphasis added). Further, Dr. Felber did not introduce any online patient reviews into evidence, and, therefore, the Panel did not consider his proffer of having received many positive online reviews.

Dr. Felber next appears to argue in his exceptions that the State's expert witness testimony should not have been relied on because he was younger and less experienced and less accomplished then Dr. Felber and was "inaccurate." The Panel denies Dr. Felber's exception. As an initial matter, the State's expert was qualified to testify as an expert in family medicine, urgent care medicine, and medical documentation in an urgent care environment. Like Dr. Felber, the State's expert is board-certified in family medicine. The State's expert graduated from Osteopathic

medical school one year after Dr. Felber did. The State's expert had significant training and experience in family medicine and urgent care. At the time when the State's expert conducted his peer review of Dr. Felber's patients, the State's expert had been in medical practice for twelve years, had been board-certified for nine years, worked at a multi-site family medicine group for eight years, and supervised, trained, and oversaw residents as a Clinical Associate Professor in Family Medicine and Geriatrics for seven years. The State's expert's qualifications were more than adequate.

The Panel also adopts the State's expert's opinions based on the logic and persuasiveness of his testimony. "[T]he Board may make its own decisions about bias, interest, credentials of expert witnesses, the logic and persuasiveness of their testimony, and the weight to be given their opinions." *State Bd. of Physicians v. Bernstein*, 167 Md. App. 714, 761 (2006). The Panel agrees with the ALJ's assessment that the State's expert's testimony was persuasive as to the standard of care for all patients but Patient 7. With respect to medical recordkeeping, the ALJ found the State's expert to be persuasive for all patients except Patient 8, whose records the State's expert found inadequate but which the ALJ found adequate. The Panel finds that the State's expert's opinion is persuasive for all Patients 1-11. This analysis was based on the logic and persuasiveness of his testimony and considering Dr. Felber's cross-examination.

Finally, Dr. Felber claimed that State's expert's testimony was inaccurate and stated that the State's expert "wanted to X-ray every child that walked into the clinic." The Panel rejects this claim. The State's expert stated that Dr. Felber should have ordered an x-ray for Patient 6, a nine-year-old boy, who was hit in the face with a baseball. The Panel agrees with the State's expert's opinion that an x-ray should have been performed in that instance. Dr. Felber's exception is rejected.

CONCLUSIONS OF LAW

Disciplinary Panel B concludes, as a matter of law, that Dr. Felber violated Health Occ. § 14-404(a)(22) by failing to meet the 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 for Patients 1, 2, 3, 4, 5, 6, 9, and 10. The Panel does not find that Dr. Felber violated the standard of care in his treatment of Patient 7.

The Panel concludes that Dr. Felber violated Health Occ. § 14-404(a)(40) by failing to keep adequate medical records as determined by appropriate peer review for Patients 1 - 11.

SANCTION

The ALJ recommended a sanction of a reprimand and a six-month probation, with conditions that included a peer supervisor and completion of a course in medical documentation. The State requested the same sanction but argued that the probation should be for a period of two years rather than six months. Dr. Felber argued that no period of probation should be imposed because probation "will defame my name and reputation for the foreseeable future. The punishment should fit what occurred."

The Panel agrees with the State that six months of probation is an insufficient period for Dr. Felber's supervision. The Panel imposes a sanction of a reprimand and a one-year period of probation with conditions that Dr. Felber have a peer supervisor and complete a medical recordkeeping course. The one-year probationary period will give Dr. Felber ample time to improve his medical practices and recordkeeping practices with the guidance of a peer supervisor.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by an affirmative vote of a majority of a quorum of Disciplinary Panel B, hereby

ORDERED that Eric S. Felber, D.O., is **REPRIMANDED**; and it is further

ORDERED that Dr. Felber is placed on **PROBATION** for a minimum period of **ONE YEAR**.[4] During the probationary period, Dr. Felber shall comply with the following probationary terms and conditions:

1. For the duration of the probation, Dr. Felber's medical practice shall be supervised, at his own expense, by a disciplinary panel-approved physician peer supervisor who is board-certified in family medicine;

(a) As part of the approval process, Dr. Felber shall provide the disciplinary panel, **WITHIN 30 DAYS**, with the name, pertinent professional background information of the supervisor whom Dr. Felber is offering for approval, and written notice to the disciplinary panel from the supervisor confirming his or her acceptance of the supervisory role of Dr. Felber and that there is no personal or professional relationship with the supervisor;

(b) Dr. Felber's proposed supervisor, to the best of Dr. Felber's knowledge, should not be an individual who is currently under investigation, and has not been disciplined by the Board within the past five years;

(c) if Dr. Felber fails to provide a proposed supervisor's name within 30 calendar days from the effective date of the order, Dr. Felber's license shall be automatically suspended from the 31st day until Dr. Felber provides the name and background of a supervisor;

(d) the disciplinary panel, in its discretion, may accept the proposed supervisor or request that Dr. Felber submit a name and professional background, and written notice of confirmation from a different supervisor;

(e) the supervision begins after the disciplinary panel approves the proposed supervisor;

(f) the disciplinary panel will provide the supervisor with a copy of this Final Decision and Order and any other documents the disciplinary panel deems relevant;

(g) Dr. Felber shall grant the supervisor access to patient records selected by the supervisor, which shall, to the extent practicable, focus on the type of treatment at issue in Dr. Felber's charges;

(h) if the supervisor for any reason ceases to provide supervision, Dr. Felber shall immediately notify the Board and shall not practice medicine beyond the 30th day after the supervisor has ceased to provide supervision and until Dr. Felber has submitted the name

[4] If Dr. Felber's license expires while he is on probation, the probationary period and any probationary conditions will be tolled. COMAR 10.32.02.05C(3).

and professional background, and written notice of confirmation, from a proposed replacement supervisor to the disciplinary panel;

(i) it shall be Dr. Felber's responsibility to ensure that the supervisor:

(1) reviews the records of 10 patients each month, such patient records to be chosen by the supervisor and not Dr. Felber and the supervisor shall choose patient records from a pool of all of the Respondent's patients;

(2) meets with Dr. Felber in-person (or in real-time if in-person is not feasible) at least once each month and discuss with Dr. Felber the care Dr. Felber has provided for these specific patients;

(3) be available to Dr. Felber for consultations on any patient;

(4) maintains the confidentiality of all medical records and patient information;

(5) provides the Board with quarterly reports which detail the quality of Dr. Felber's practice, any deficiencies, concerns, or needed improvements, as well as any measures that have been taken to improve quality of care and quality of documentation; and

(6) immediately reports to the Board any indication that Dr. Felber may pose a substantial risk to patients;

(j) Dr. Felber shall follow any recommendations of the supervisor;

(k) if the disciplinary panel, upon consideration of the supervisory reports and Dr. Felber's response, if any, has a reasonable basis to believe that Dr. Felber is not meeting the standard of quality care or failing to keep adequate medical records in his practice, the disciplinary panel may find a violation of probation after a hearing.

2. Within **SIX (6) MONTHS**, Dr. Felber is required to take and successfully complete a course in medical recordkeeping. The following terms apply:

(a) It is Dr. Felber's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the course before the course is begun;

(b) The disciplinary panel will not accept a course taken over the internet;

(c) Dr. Felber must provide documentation to the disciplinary panel that he has successfully completed the course;

(d) The course may not be used to fulfill the continuing medical education credits required for license renewal;

(e) Dr. Felber is responsible for the cost of the course; and it is further

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

ORDERED that after Dr. Felber has complied with all terms and conditions of probation and the minimum period of probation imposed by this Order has passed, Dr. Felber may submit to the Board a written petition for termination of probation. After consideration of the petition, the probation may be terminated through an order of the disciplinary panel. Dr. Felber may be required to appear before the disciplinary panel to discuss his petition for termination. The disciplinary panel may grant the petition to terminate the probation, through an order of the disciplinary panel, if Dr. Felber has complied with all probationary terms and conditions, and there are no pending complaints relating to the charges; and it is further

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

ORDERED that Dr. Felber 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 the Final Decision and Order is the date the Final Decision and Order is signed by the Executive Director of the Board. The Board's Executive Director signs the Final Decision and Order on behalf of the Panel; and it is further

ORDERED that, if Dr. Felber allegedly fails to comply with any term or condition imposed by this Order, Dr. Felber 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, Dr. Felber 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. Felber has failed to comply with any term or condition imposed by this Order, the disciplinary panel may reprimand Dr. Felber, place Dr. Felber on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke Dr. Felber'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 Dr. Felber; and it is further

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

08/24/2020
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(a), Dr. Felber 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. Felber 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:

David Finkler
Assistant Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

Exhibit 1

MARYLAND STATE BOARD OF PHYSICIANS	*	**BEFORE MICHAEL R. OSBORN, AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE**
ERIC S. FELBER, DO,	*	**OF ADMINISTRATIVE HEARINGS**
RESPONDENT	*	
LICENSE No.: H70831	*	**OAH No.: MDH-MBP1-71-19-06702**

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PROPOSED DECISION

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

STATEMENT OF THE CASE

On September 24, 2018, a disciplinary panel of the Maryland State Board of Physicians (Board) issued charges against Eric S. Felber, D.O. (Respondent) alleging violations of State law governing the practice of medicine. Md. Code Ann., Health Occ. §§ 14-101 through 14-508, and 14-601 through 14-607 (2014 & Supp. 2019). Specifically, the Respondent is charged with violating sections 14-404(a)(22) (failing to meet appropriate standards for delivery of medical and surgical care in an outpatient facility as determined by peer review) and 14-404(a)(40) (failing to keep adequate medical records). On March 4, 2019, the Respondent requested a hearing on the Board's charges. The disciplinary panel to which the complaint was assigned forwarded the charges to the Office of the Attorney General for prosecution, and another disciplinary panel delegated the matter to the Office of Administrative Hearings (OAH) for

issuance of proposed findings of fact, proposed conclusions of law, and proposed disposition. COMAR 10.32.02.03E(5); COMAR 10.32.02.04B(1).

On March 20, 2019, Ferrier R. Stillman, Esquire, Kerianne Kemmerzell, Esquire, and Tydings & Rosenberg, LLP entered their appearance on behalf of the Respondent. On April 2, 2019, I conducted an in-person scheduling conference at the OAH in Hunt Valley, Maryland. Ms. Kemmerzell represented the Respondent, who was present. Victoria H. Pepper, Assistant Attorney General, Administrative Prosecutor, appeared on behalf of the State of Maryland (State). The dates for the prehearing conference, the submission of prehearing conference statements, the exchange of exhibits and the hearing on the merits were set at that time with the agreement of the parties based on their availability. On April 10, 2019, I issued a Scheduling Conference Report and Order reflecting those determinations.

On April 19, 2019, M. Natalie McSherry, Esquire, entered a Conditional Entry of Appearance for the Respondent, indicating therein that Ms. Stillman was unable to participate further due to health reasons. As part of her Conditional Entry of Appearance, Ms. McSherry provided her dates of availability. On April 22, 2019, Ms. Pepper responded that the State's witness would not be available on the dates Ms. McSherry was available.

On April 29, 2019, I conducted another in-person Scheduling Conference attended by Ms. Pepper, Ms. McSherry and Ms. Kemmerzell. Ms. Kemmerzell, Ms. Stillman and Tydings & Rosenberg, LLP were excused from further participation and Ms. McSherry's appearance as counsel was entered. The dates for the prehearing conference, the submission of prehearing conference statements, the exchange of exhibits and witness lists, and the hearing on the merits were set at that time with the agreement of the parties based on their availability. The hearing

on the merits was set for July 24 through 26, 2019. On May 9, 2019, I issued a Supplemental Scheduling Conference Report and Order, reflecting those determinations.

On May 20, 2019, Ms. McSherry withdrew her appearance a counsel.

On June 27, 2019, I conducted an in-person Prehearing Conference, during which I addressed issues raised by the parties. Although she appeared late, Ms. Pepper participated on behalf of the State. The Respondent appeared and represented himself. He indicated he would be representing himself for the remainder of the proceedings.

On June 28, 2019, the Respondent filed a request for mistrial based on Ms. Pepper's tardiness at the June 27, 2019 Prehearing Conference and argued the OAH improperly contacted her about her appearance. I denied that motion in writing on July 16, 2019.

On July 24, 2019, the Board revised its charging document to correct the dates of the Respondent's specialty certification in family medicine, from "lapsed in or around early 2018" to "renewed through December 31, 2026."

I held a hearing on the merits on July 24 and 25, 2019, at the OAH in Hunt Valley, Maryland. Health Occ. § 14-405(a) (Supp. 2019); COMAR 10.32.02.04. The Respondent represented himself. Ms. Pepper represented the State.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules for Hearings before the Board, and the Rules of Procedure of the OAH, Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2014 & Supp. 2019); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

1. Did the Respondent fail 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 with regard to his treatment of Patients 1-11?

2. Did the Respondent fail to keep adequate medical records as determined by appropriate peer review with regard to his treatment of Patients 1-11?

3. If so, what sanction is appropriate, if any?

SUMMARY OF THE EVIDENCE

Exhibits

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

Bd. Ex. 1 – Complaint, dated December 4, 2017;
Bd. Ex. 2 – Subpoena Duces Tecum issued to Respondent for Complainant's records, dated December 18, 2017;
Bd. Ex. 3 – Respondent's Response to Complaint, dated December 23, 2017;
Bd. Ex. 4 – Subpoena Duces Tecum issued to Respondent for 10 patient records, dated January 19, 2018;
Bd. Ex. 5 – Correspondence from Board staff to Respondent with Subpoena Duces Tecum for billing records, dated March 8, 2018;
Bd. Ex. 6 – Subpoena Ad Testificandum issued to Respondent, dated March 26, 2018;
Bd. Ex. 7 – Compliance Analyst Memo to file, dated April 9, 2018;
Bd. Ex. 8 – Transcript of Respondent's Interview, dated April 19, 2018;
Bd. Ex. 9 – Patient 1 [redacted] Respondent's medical record and billing record;
Bd. Ex. 10 – Patient 2 [redacted] Respondent's medical record and billing record;
Bd. Ex. 11 – Patient 3 [redacted] Respondent's medical record and billing record;
Bd. Ex. 12 – Patient 4 [redacted] Respondent's medical record and billing record;
Bd. Ex. 13 – Patient 5 [redacted] Respondent's medical record and billing record;
Bd. Ex. 14 – Patient 6 [redacted] Respondent's medical record and billing record;
Bd. Ex. 15 – Patient 7 [redacted] Respondent's medical record and billing record;
Bd. Ex. 16 – Patient 8 [redacted] Respondent's medical record and billing record;
Bd. Ex. 17 – Patient 9 [redacted] Respondent's medical record and billing record;
Bd. Ex. 18 – Patient 10 [redacted] Respondent's medical record and billing record;
Bd. Ex. 19 – Patient 11 [redacted] Respondent's medical record and billing record;
Bd. Ex. 20 – *Curriculum Vitae* – [redacted] D.O.;
Bd. Ex. 21 – Peer Review Report – Dr. [redacted], July 9, 2018
Bd. Ex. 22 – Respondent's Response to Peer Review, July 16, 2018;
Bd. Ex. 23 – Advisory Letter, dated March 1, 2016;
Bd. Ex. 24 – Advisory Letter, dated October 18, 2016;
Bd. Ex. 25 – Advisory Letter, dated January 4, 2018;
Bd. Ex. 26 – Advisory Letter, dated January 19, 2018;
Bd. Ex. 27 – Charges Under the Maryland Medical Practice Act, dated September 24, 2018.

The Respondent did not offer any exhibits.

Testimony

The following witnesses testified on behalf of the Board:

1. Patient 7 of West Palm Beach, Florida, testified by teleconference, and
2. [redacted], D.O., who was accepted as an expert in family medicine, urgent care medicine, and medical documentation in an urgent care environment.

The Respondent testified on his own behalf and presented the following witness:

[redacted], Compliance Analyst for the Board.

PROPOSED FINDINGS OF FACT

Having considered all of the evidence presented, I find the following facts by a preponderance of the evidence:

The Respondent

1. At all times relevant to this proceeding, the Respondent was a licensed physician in the State of Maryland, board certified in family medicine.

2. At all times relevant to this proceeding, the Respondent maintained an urgent care facility and practiced medicine in the area of urgent care in Bethesda, Maryland.

Patient Complaint and Board Investigation

3. On December 4, 2017, the Board received a complaint from a patient (Patient 7). The complaint alleged Patient 7 was seen by the Respondent on October 24, 2017, and the visit included an electrocardiogram (EKG). Patient 7 alleged she visited the Respondent's facility on November 28, 2017 for a pre-surgical examination for surgery scheduled November 30, 2017. As part of the November 28, 2017 visit, she asked the Respondent to give her a copy of the October 24, 2017 EKG, which was ordered by her surgeon. She complained the Respondent

insisted a new EKG would be faster and easier. According to the complaint, the Respondent yelled at Patient 7, told her she was trespassing, and threatened to call the police if she did not leave. Patient 7 alleged she felt threatened by the Respondent and feared for her safety.

4. After receipt of Patient 7's complaint, the Board launched an investigation. On December 18, 2017, it issued a subpoena to the Respondent for Patient 7's records. On December 23, 2017, the Respondent produced the subpoenaed records with an explanation attached.

5. On January 19, 2018, the Board subpoenaed the records, including billing records, of ten additional patients from the Respondent. As part of its request for records the Board requested the Respondent provide a summary of care for each patient whose records were subpoenaed, and to submit the records, with a summary of care, to the Board within ten days. The Respondent complied and the Board referred the subpoenaed records of the ten additional patients, and the records of Patient 7, for peer review.

The Applicable Standard for Delivery of Quality Medical Care[1]

6. In providing care to a patient, including the prescription of medications, a Physician must:

- take a complete history including current and past medical diagnoses;
- inquire about current medications, past medications, and allergies to medications, food and environmental factors;

[1] The term "standard of care" as it relates to medical malpractice actions and, by extension, to physician disciplinary proceedings, has been defined in *Shilkret v. Annapolis Hospital Association*, 276 Md. 187 (1975). In that case, the Court of Appeals set out the legal meaning of "standard of care" as follows:
[A] physician is under a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same or similar class to which he belongs, in the same or similar circumstances. Under this standard, advances in the profession, availability of facilities, specialization or general practice, proximity of specialists and special facilities, together with all other relevant considerations are to be taken into account. *Id.* at 200-201; *see also Reed v. Campagnolo*, 332 Md. 226, 233 (1993).

• inquire about family medical history;

• inquire about social history including use of alcohol or social drugs;

• inquire about the subjective view of symptoms, including their possible cause, and inquire whether the medical problem presented is accompanied by fever, headaches, pain, or discomfort

• inquire whether the symptoms have been treated and, if so, how, and whether the treatment was successful;

• conduct a physical examination and evaluation to reach objective findings, including vital signs;

• conduct diagnostic tests (laboratory tests such as a complete blood count (CBC), a comprehensive metabolic panel (CMP), x-ray, magnetic resonance imaging (MRI), computed tomography (CT), EKG), or such other objective tests as are called for based on the medical issue presented; and

• develop a treatment plan consistent with the diagnosis and history that includes measurable and verifiable treatment outcomes, and which is designed to address the medical problem presented.

7. In providing care to a patient, a physician must refer the patient, when appropriate, for consultation with a physician with special experience and expertise in areas of concern. When so referred, a treating physician must take into consideration any recommendations of the physician to whom the patient was referred for consultation, and must discuss those recommendations with patients.

8. The standard of care requires that psychotropic drugs be prescribed for long-term use only by physicians with special expertise in the management of patients who require such medications.

9. The standard of care for administration of long-term psychotropic drugs does not require they be administered by a physician with special expertise in the management of patients who require such medications.

Standard for Adequacy for Keeping Medical Records

10. A physician must document the steps taken in the design of a treatment plan that includes: the patient's most recent complaints; objective findings; a social and family history to the extent it affects present care decisions; a history of prior complaints to the extent prior complaints are related to present complaints; a history of the medications previously prescribed; a description of any new medications prescribed and the reason why medications were increased, decreased, or changed, including dose and frequency; treatment objectives, and a description of progress made in achieving those objectives. The documentation must be sufficient in scope, detail and clarity to enable another physician, unfamiliar with the patient, to undertake care of the patient and to understand, from the treating physician's records, the patient's current medical condition, treatment plan and objectives, the extent to which treatment objectives are being achieved, and if not being achieved, why.

11. The commonly accepted method for medical record entries is the acronym SOAP, which refers to the following:

S- Subjective complaints of patient.

O- Objective observations (physical exam) or actions that the physician takes.

A- Assessment, or what the physician thinks about the problem.

P- Plan is the action the physician plans to take to address the problem.

The Patients

Patient 1, [redacted]

12. Patient 1 was an eleven-year-old girl seen by the Respondent on September 10, 2017, for a sore throat. Patient 1's vital signs, except for her blood pressure, were taken and recorded, and her subjective complaints of pain were recorded. The Respondent noted subjective complaints that Patient 1's mother had a strep throat, and that Patient 1 was allergic to penicillin. Among the objective assessments was "Strep +".

13. The Respondent's examination notes make no mention that Patient 1's lymph nodes were enlarged, or that her throat was inflamed or reddened – both common signs of strep throat.

14. The Respondent recorded the following objective findings for Patient 1: "GEN (general): NAD (no acute distress), ALERT- HEENT: (head, ears, eyes, nose and throat): NCAT (normal cephalic atraumatic); EOMI (extraocular muscles intact), TRACHEA MIDLINE, PHARYNX CLEAR. CV (cardiovascular): NO DISTRESS ABD: NO DISTENTION EXT: NO EDEMA (no abnormal fluid retention)."

15. The Respondent's assessment for Patient 1 was strep throat, and the treatment plan included administration of 800 mg. of Amoxicillin in a liquid suspension per day for ten days.

16. The Respondent's records for Patient have no reference to any examination of her lymph nodes.

17. Amoxicillin is in the same family of drugs as penicillin and may cause severe allergic reactions to those allergic to penicillin.

18. In response to the Board's request the Respondent summarize his care for Patient 1, the Respondent noted on an insurance claim form "[Patient 1] had strep throat and was prescribed amoxicillin liquid."

19. The Respondent electronically signed Patient 1's medical record entries on January 29, 2018 for care provided on September 10, 2017.

20. The Respondent failed to deliver quality medical care to Patient 1.

21. The Respondent failed to maintain adequate medical records as to Patient 1.

Patient 2, [redacted]

22. Patient 2 was a forty-seven year-old man seen by the Respondent on December 12, 2017 for a sore throat.

23. The Respondent did not record any vital signs for Patient 2. The Respondent included subjective complaints of a sore throat, without fever or headaches. The Respondent noted objective findings that included "pharynx clear" and "Strep -."

24. The Respondent prescribed an antibiotic for a sore throat without any medically-justifiable reason, especially with a negative strep test.

25. The Respondent did not perform a lung exam when such an exam may have revealed an infection.

26. For treatment of Patient 2's sore throat the Respondent prescribed a "Z-pack," an antibiotic for treatment of acute bronchitis or pneumonia.

27. For objective findings for Patient 2, the Respondent recorded: "GEN: NAD, ALERT HEENT: NCAT, EOMI, TRACHEA MIDLINE, PHARYNX CLEAR. CV: NO DISTRESS. ABD: NO DISTENTION. EXT: NO EDEMA."

28. In response to the Board's request the Respondent summarize his care for Patient 2, the Respondent noted on an insurance claim form "[Patient 2] had non-stop pharyngitis. A z-pack was rx'd."

29. The Respondent electronically signed Patient 2's medical record entries on January 29, 2018 for care provided on December 12, 2017.

30. The Respondent failed to deliver quality medical care to Patient 2.

31. The Respondent failed to maintain adequate medical records as to Patient 2.

Patient 3, [redacted]

32. Patient 3 was a sixty-five year-old woman seen by the Respondent on September 10, 2017 for a tetanus shot.

33. No vital signs for Patient 3 were recorded.

34. The Respondent did not conduct a basic and focused physical examination that included the heart and lungs, examination of the puncture site, and a tetanus shot history.

35. As objective findings for Patient 3 the Respondent recorded: "GEN: NAD, ALERT HEENT: NCAT, EOMI, TRACHEA MIDLINE, PHARYNX CLEAR. CV: NO DISTRESS. ABD: NO DISTENTION. EXT: NO EDEMA."

36. The Respondent assessed the complaint as a puncture, but did not say where the puncture was. He administered a tetanus shot.

37. In response to the Board's request for a summary of care for Patient 3 the Respondent indicated "[Patient 3] had a laceration to right knee. Td was given."

38. The Respondent electronically signed Patient 3's medical record entries on January 29, 2019 for care provided on September 10, 2017.

39. The Respondent failed to deliver quality medical care to Patient 3.

40. The Respondent failed to maintain adequate medical records as to Patient 3.

Patient 4 [redacted]

41. Patient 4 was a forty-two year old man seen by the Respondent on September 10, 2017 for a sore throat and a strep check.

42. Patient 4's subjective complaints included that his throat had been sore for five days, with headaches.

43. For objective findings for Patient 4 the Respondent recorded: "GEN: NAD, ALERT HEENT: NCAT, EOMI, TRACHEA MIDLINE, and PHARYNX CLEAR. CV: NO DISTRESS. ABD: NO DISTENTION. EXT: NO EDEMA."

44. The Respondent's objective findings included "Strep -."

45. The Respondent failed to perform a lung examination or examine Patient 4's lymph nodes. He recorded "pharynx clear" as an objective assessment, which is inconsistent with a patient who presents with complaints of a sore throat.

46. The Respondent's assessment for Patient 4 was pharyngitis.

47. For treatment of Patient 4's pharyngitis the Respondent prescribed a "Z-pack," an antibiotic for treatment of acute bronchitis or pneumonia. There is no medically-sound reason to prescribe a z-pack, an antibiotic, to treat a sore throat when a throat culture is negative.

48. In response to the Board's request the Respondent summarize his care for Patient 4, the Respondent noted on an insurance claim form "[Patient 4] had non-stop pharyngitis. A z-pack was prescribed."

49. The Respondent electronically signed Patient 4's medical record entries on January 29, 2018 for care provided on September 10, 2017.

50. The Respondent failed to deliver quality medical care to Patient 4.

51. The Respondent failed to maintain adequate medical records as to Patient 4.

Patient 5, [redacted]

52. Patient 5 was a fifty-five year old woman seen by the Respondent on September 10, 2017 with complaints of an object in her foot.

53. The Respondent did not record any vital signs for Patient 5.

54. For objective findings for Patient 5 the Respondent recorded: "GEN: NAD, ALERT HEENT: NCAT, EOMI, TRACHEA MIDLINE, and PHARYNX CLEAR. CV: NO DISTRESS. ABD: NO DISTENTION. EXT: NO EDEMA."

55. The Respondent failed to inquire about Patient 5's history of infections, cardiac problems or whether Patient 5 was on a blood thinner. His records do not describe which foot was injured, whether an anesthetic was used, what suture, if any, was used to close the wound, and whether the Patient was offered a tetanus shot.

56. There is no reference to whether an antibiotic was administered, and no reference to whether the Respondent provided wound care instructions.

57. The Respondent's objective assessment was "FB FOOT." His treatment plan included "I AND D PERFORMED, FB REMOVED, and FOLLOW-UP PRN." This meant incision and drainage, removal of a foreign body, and follow-up as needed.

58. In response to the Board's request the Respondent summarize his care of Patient 5, the Respondent circled "I AND D PERFORMED, FB REMOVED, FOLLOW-UP PRN" on Patient 5's record.

59. The Respondent electronically signed Patient 5's medical record entries on January 29, 2018 for care provided on September 10, 2017.

60. The Respondent failed to deliver quality medical care to Patient 5.

61. The Respondent failed to maintain adequate medical records as to Patient 5.

Patient 6, [redacted]

62. Patient 6 was a nine-year-old boy seen by the Respondent on September 10, 2017 with complaints of being hit by a baseball.

63. The Respondent did not record any vital signs for Patient 6.

64. The Respondent's subjective observations were that Patient 6 was hit by a baseball, that he had no fever or headaches, and had mild and intermittent pain.

65. For objective findings for Patient 6 the Respondent recorded: "GEN: NAD, ALERT HEENT: NCAT, EOMI, TRACHEA MIDLINE, PHARYNX CLEAR. CV: NO DISTRESS. ABD: NO DISTENTION. EXT: NO EDEMA."

66. The Respondent made no reference to examination of Patient 6 for a bruise or abrasion, and made no reference to where Patient 6 was hit by a baseball.

67. The Respondent's medical records for Patient 6 make no reference to whether any kind of imaging was considered or offered. There is no reference to whether Patient 6 lost consciousness when struck, and no reference to whether Patient 6's parents were instructed about warning signs of a concussion or subdural hemorrhage.

68. The Respondent's assessment was "contusion."

69. The Respondent's treatment plan included reassurance and non-steroidal anti-inflammatory drugs, increased hydration and rest.

70. In response to the Board's request the Respondent summarize his care for Patient 6 the Respondent circled Patient 6's primary diagnosis insurance code on insurance billing documentation, and wrote on the insurance documentation "[Patient 6] was hit in face with baseball. No fracture seen. Reassurance and NSAIDs/ice."

71. The Respondent electronically signed Patient 6's medical record entries on January 29, 2018 for care provided on September 10, 2017.

72. The Respondent failed to deliver quality medical care to Patient 6.

73. The Respondent failed to maintain adequate medical records as to Patient 6.

Patient 7, [redacted]

74. Patient 7 was a seventy-six year old woman seen by the Respondent on November 28, 2017 for a pre-surgical examination for a surgery scheduled November 30, 2017. Patient 7 was accompanied by her daughter,

75. The specific type of surgery was not recorded by the Respondent.[2]

76. The Respondent conducted an examination which included vital signs, pre-operative lab work, an evaluation of drug and food allergies, an evaluation of current medications, a discussion of past medical events and a discussion of Patient 7's family medical history.

77. For objective findings for Patient 7 the Respondent recorded: "GEN: NAD, ALERT HEENT: NCAT, EOMI, TRACHEA MIDLINE, PHARYNX CLEAR. CV: NO DISTRESS, ABD: NO DISTENTION. EXT: NO EDEMA, and "BLOODWORK PENDING."

78. The Respondent's assessment was "PRE-OP EXAM."

79. The Respondent cleared Patient 7 for surgery and electronically signed Patient 7's medical record entries on November 28, 2017.

[2] Patient 7 testified at the hearing that she was scheduled for carpal-tunnel surgery, and that the surgery went well.

80. The Respondent's medical records for Patient 7's pre-surgical visit do not include a social history, family history or smoking history. A surgeon and anesthesiologist rely on these factors in their risk assessment.

81. On October 24, 2017, Patient 7 was seen at the Respondent's clinic for a pre-operative examination for a wrist surgery scheduled October 27, 2017. She was seen by [redacted], a physician's assistant. As part of this visit, PA [redacted] ordered an EKG, a CBC, a CMP, and conducted a pre-surgical physical examination. Following examination, PA [redacted] cleared Patient 7 for surgery.

82. On October 25, 2017, the Respondent accepted PA [redacted]'s pre-surgical report.

83. Patient 7's visit to the Respondent's clinic on November 28, 2017 for a pre-surgical examination was not previously scheduled by Patient 7. Nevertheless, the Respondent performed the requested pre-surgical examination. Patient 7 requested she be provided with a copy of the EKG taken October 24, 2017. The Respondent tried unsuccessfully to convince Patient 7 to allow him to take a new EKG.

84. When the Respondent expressed his desire that Patient 7 undergo a new EKG, and the Patient declined renewing her request that the October 24, 2017 EKG be provided to her, the Respondent, Patient 7, and Patient 7's daughter became engaged in a heated discussion that ended with the Respondent telling Patient 7 to leave his clinic or he would call the police.

85. On November 29, 2017, the Respondent forwarded the results of his November 28, 2017 examination and the EKG of October 24, 2017 to Patient 7's surgeon.[3]

86. On November 30, 2017, Patient 7's surgeon performed the scheduled surgery.

87. The Respondent did not fail to deliver quality medical care to Patient 7.

88. The Respondent failed to maintain adequate medical records as to Patient 7.

Patient 8, [redacted]

89. Patient 8 was a fifty-six year old woman seen by the Respondent's clinic on December 17, 2017, to administer a fluphenazine injection.

90. Fluphenazine is a drug administered for schizophrenia and other psychotic disorders.

91. Patient 8 was seen on December 17, 2017 by [redacted].

92. Ms. [redacted] did not record any vital signs.

93. Patient 8's medical record includes subjective observations of no fever or headaches, no over-the-counter supplements, and no prior episodes.

94. For objective findings for Patient 8 Ms. [redacted] recorded: "GEN: NAD, ALERT HEENT: NCAT, EOMI, TRACHEA MIDLINE, PHARYNX CLEAR. CV: NO DISTRESS ABD: NO DISTENTION EXT: NO EDEMA."

95. Patient 8's assessment on December 17, 2017 was schizophrenia. The treatment plan was "her home medication injected, F/U PRN" (follow up as needed).

[3] PA [redacted]'s pre-surgical evaluation of October 24, 2017 is significantly more thorough and contains significantly more information for the reader than the Respondent's pre-surgical evaluation of November 28, 2017. The record is silent as to whether the carpal-tunnel surgery scheduled November 30, 2017 was the same "wrist surgery" described in PA [redacted]'s pre-surgical evaluation of October 24, 2017, and is equally silent as to whether the surgeon is the same. Therefore, I have no evidence upon which to conclude the surgeon had both PA [redacted]'s evaluation and the Respondent's evaluation to assist the surgeon in deciding whether to proceed with the surgery.

96. Patient 8 was also seen at the Respondent's clinic on December 3, 2017 for injection of her fluphenazine. She was seen by [redacted].

97. No vital signs were recorded on December 3, 2017.

98. The objective findings of December 3, 2017 are identical to the objective findings of December 17, 2017.

99. Patient 8 was also seen at the Respondent's clinic on November 19, 2017, for injection of fluphenazine. She was seen by [redacted].

100. No vital signs were taken on November 19, 2017.

101. The objective findings of November 19, 2017 are identical to the objective findings of December 17, 2017 and December 3, 2017.

102. Patient 8 was also seen at the Respondent's clinic for injection of fluphenazine on October 21, 2017. She was seen by the Respondent.

103. The Respondent did not record any vital signs.

104. The Respondent's objective findings of October 21, 2017 are identical to the objective findings recorded by the Respondent's clinic on December 17, 2017, December 3, 2017, and November 19, 2017.

105. Patient 8 was also seen by the Respondent's clinic for injection of fluphenazine on October 8, 2017. She was seen by [redacted].

106. The objective findings of October 8, 2017 are identical to the objective findings of December 17, 2017, December 3, 2017, November 19, 2017, and October 21, 2017.

107. Patient 8 was seen at the Respondent's clinic for injection of fluphenazine on September 10, 2017. She was seen by the Respondent.

108. The Respondent did not record any vital signs.

109. The Respondent's objective findings of September 10, 2017 are identical to the objective findings on Patient 8's medical records for visits on December 17, 2017, December 3, 2017, November 19, 2017, October 21, 2017, and October 8, 2017.

110. On January 29, 2018, the Respondent electronically signed medical records entries for Patient 8 for her visits on December 17, 2017, December 3, 2017, November 19, 2017, October 21, 2017, October 8, 2017, and September 10, 2017.

111. In response to the Board's request the Respondent summarize his care for Patient 8, the Respondent wrote on an insurance form "[Patient 8] comes for her antipsychotic drug administration."

112. The Respondent did not fail to deliver quality medical care to Patient 8.

113. The Respondent kept adequate medical records as to Patient 8.

Patient 9, [redacted]

114. Patient 9 was a forty-year old man who was seen by the Respondent on September 10, 2017 for shoulder pain.

115. The Respondent did not record any vital signs.

116. The Respondent recorded Patient 9's subjective symptoms, recorded his objective findings, and assessed Patient 9 as having tendonitis. For objective findings for Patient 9 the Respondent recorded: "GEN: NAD, ALERT HEENT: NCAT, EOMI, TRACHEA MIDLINE, PHARYNX CLEAR. CV: NO DISTRESS. ABD: NO DISTENTION. EXT: NO EDEMA."

117. The Respondent's objective findings included no mention of any examination of Patient 9's right shoulder, whether it was tender, whether its range of movement was limited, or any description of whether Patient 9 had injured the shoulder in an accident or while getting some exercise or otherwise.

118. The Respondent did not mention any mechanism of injury or origin of the pain, and did not order any imaging. He did not instruct Patient 9 to limit movement or increase movement to restore function, and did not instruct Patient 9 on how to avoid further injury or aggravation.

119. The Respondent's treatment plan included reassurance, non-steroidal anti-inflammatory drugs, hydration and rest, with instructions to return if the pain worsened.

120. Patient 9 was also seen by the Respondent on August 2, 2017 for complaints of bloody stools for the past three days, accompanied by pain in the left lower quadrant.

121. The Respondent recorded Patient 9's vital signs, and recorded Patient 9's subjective assessment.

122. The Respondent recorded his objective findings including a comprehensive description of a chest and lung examination, a cardiac evaluation, his examination of Patient 9's abdomen, and a rectal examination.

123. The Respondent ruled out diverticulitis, and as a treatment plan sent Patient 9 to the emergency room and wrote a referral to a gastroenterologist.

124. The Respondent electronically signed Patient 9's medical records entries for Patient 9's visit on August 2, 2017 on August 2, 2017, although the electronic signature is that of [redacted]

125. On January 29, 2018, the Respondent electronically signed Patient 9's medical record for his clinic visit on September 10, 2017.

126. In response to the Board's request the Respondent summarize his care for Patient 9, the Respondent wrote on an insurance billing statement "[Patient 9] here for a flu test which was negative. Reassure."

127. The Respondent failed to deliver quality medical care to Patient 9 regarding the visit for shoulder pain.

128. The Respondent failed to maintain adequate medical records as to Patient 9.

Patient 10, [redacted]

129. Patient 10 was a thirty-two year old man seen by the Respondent on September 10, 2017 for right hand pain from a car accident on September 6, 2017.

130. The Respondent took Patient 10's vital signs.

131. As part of his evaluation the Respondent noted Patient 10 had no current diagnosis; no historical diagnosis; no known drug allergies; no food allergies; no environmental allergies; no known medications; no historical medications recorded; and no smoking history available. The Respondent also recorded for Patient 10's past medical history that Patient 10: denied major medical events; denied any ongoing medical problems; and denied a family health history. The Respondent also noted no family medical history was recorded.

132. For objective findings for Patient 10 the Respondent recorded: GEN: NAD, ALERT HEENT: NCAT, EOMI, TRACHEA MIDLINE, PHARYNX CLEAR. CV: NO DISTRESS. ABD: NO DISTENTION. EXT: NO EDEMA."

133. The Respondent's assessment was "right wrist sprain – no sign of fracture."

134. There was no testing for muscle strength, reflexes, capillary refill time, or range of movement and no reference to swelling or bruising. The Respondent did not take an x-ray of Patient 10's wrist.

135. The Respondent's Patient 10 treatment plan included a wrist brace with thumb, reassurance, non-steroidal anti-inflammatory drugs as needed, increased hydration and rest.

136. In response to the Board's request the Respondent summarize his care for Patient 10 the Respondent circled "self pay" on the "payment preference" line of Patient 10's medical record, and wrote "USAA billed for car accident."

137. The Respondent electronically signed Patient 10's medical records on September 10, 2017 for care provided the same day.

138. The Respondent failed to deliver quality medical care to Patient 10.

139. The Respondent failed to maintain adequate medical records as to Patient 10.

Patient 11, [redacted]

140. Patient 11 was an eighty-six year old woman seen by the Respondent on September 10, 2017 for bleeding on her arm.

141. The Respondent recorded vital signs, and inquired of Patient 11 about any current diagnoses, (none), any historical diagnoses (none), known drug allergies (none), current medications (none), and history of medications (none). The Respondent also recorded that Patient 11 denied any past medical events, denied any current medical events, denied any family medical history, denied she was receiving any preventive care, and "no family health history recorded."

142. The Respondent recorded subjective complaints by Patient 11 of bleeding on her left arm and top of her wrist since earlier in the day, noting that Patient 11 said her skin tears easily.

143. The Respondent did not describe the physical examination he performed or describe the skin tear. He recorded "no edema" as on objective finding, which is inconsistent with an open wound.

144. There is no reference to how Patient 11 sustained the injury, and no reference to whether Patient 11's tetanus shot was current. Patient 11's medical record has no reference to instructions the Respondent gave Patient 11 as to wound care after she returned home, and no reference to whether any kind of dressing other than dermabond was applied to Patient 11.

145. For objective findings for Patient 11 the Respondent recorded: "GEN: NAD, ALERT HEENT: NCAT, EOMI, TRACHEA MIDLINE, PHARYNX CLEAR. CV: NO DISTRESS. ABD: NO DISTENTION. EXT: NO EDEMA."

146. The Respondent's assessment was "open wound arm."

147. The Respondent's treatment plan for Patient 11 included: "dermabond and pressure applied, follow up as needed."

148. The Respondent electronically signed Patient 11's medical record on January 29, 2018 for care provided September 10, 2017.

149. In response to the Board's request the Respondent summarize his care for Patient 11 the Respondent noted on insurance billing documents "[Patient 11] had bleeding on her arm. Wound care dermabond applied."

150. The Respondent failed to deliver quality medical care to Patient 11.

151. The Respondent failed to maintain adequate medical records as to Patient 11.

Prior efforts by the Board to correct the Respondent's behavior

152. On March 1, 2016, the Board issued an advisory letter to the Respondent in which it warned the Respondent that his objective findings regarding a patient were cursory. It noted the Respondent failed to record vital signs, recorded that the patient was seen for a post-operative visit but the Respondent did not record what the surgery was, and as objective findings the Respondent recorded: "HEENT; NCAT, EOMI, trachea midline, pharynx clear." The Board

also noted its concern the medical record was not electronically signed by the Respondent until six weeks after the patient's visit. The Board's letter warned the Respondent failure to maintain adequate medical records could be construed as a violation of section 14-404(a)(40) of the Health Occupations Article.

153. On October 18, 2016, the Board issued an advisory letter in which it warned the Respondent his care of a patient was substandard. The Board noted the Respondent had removed some fragments from the patient without adequate anesthesia, and perhaps without adequate preparation of the surgical site. The Board noted the Respondent failed to recommend a follow-up x-ray, and did not review the patient's tetanus history. It also noted the Respondent did not electronically sign the patient's medical record until five weeks after he provided care.

DISCUSSION

I. The Charges

The Board charged the Respondent with violations of the provisions of section 14-404(a) of the Health Occupations Article regarding each of Patients 1 through 11 in relevant part, as follows:

The Respondent failed to meet appropriate standards for the delivery of quality medical care in nine out of eleven records reviewed (Patients 1, 2, 3, 4, 5, 6, 7, 9 and 10), and failed to maintain adequate medical records in all eleven records.

The charges include that the Respondent:

- Prescribed antibiotics to patients with a negative strep test (Patients 2 and 4)
- Failed to document whether vital signs were taken (Patients 2, 3, 5, 6, 8 and 9)
- Failed to document any history of present illness (Patients 3, 4, 5, 7, 8, 10 and 11), or for some of these patients recorded incomplete, inconsistent or contradictory symptoms

• Failed to examine and failed to document adequate examinations for the medical problem presented (Patients 1, 2, 3, 4, 5, 6, 9, 10 and 11)

• Failed to document the area of a patient's injury in the medical record (Patients 3, 5, 6, 9 and 11)

• Failed to adequately document office procedures (Patients 5 and 8)

• Prescribed Amoxicillin, a penicillin-class drug, to a patient allergic to penicillin

• Failed to document a patient's past medical history, social history, family history, past issues with anesthesia, smoking history, respiratory history and cardiovascular history as part of a pre-surgical examination and evaluation.

II. Sanctions

Disciplinary proceedings against a physician are not intended to punish the offender but rather to protect the public. *McDonnell v. Comm'n on Medical Discipline*, 301 Md. 426, 436 (1984). The Court of Special Appeals has held that an administrative agency with disciplinary and licensing authority "has broad latitude in fashioning sanctions within [those] legislatively designated limits" so that it may place conditions on any suspension or probation. *Cornfeld v. State Bd. of Physicians*, 174 Md. App. 456, 486 (2007) (citing *Neutron Prods., Inc. v. Dep't of Environment*, 166 Md. App. 549, 584, *cert. denied*, 392 Md. 726 (2006) and *Blaker v. State Bd. of Chiropractic Examiners*, 123 Md. App. 243, 264-65, *cert. denied*, 351 Md. 662 (1998)).

Under sections 14-404(a)(22) and (40) of the Health Occupations Article and the cases cited above, and subject to the Respondent's right to this hearing, a disciplinary panel may reprimand any licensee, place any licensee on probation and establish conditions of probation, or suspend or revoke a license if the licensee 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 or fails to keep adequate medical records as determined by appropriate peer review.

The Board's regulations include a sanctioning matrix that reflects the minimum and maximum penalties for conduct that is subject to disciplinary action. COMAR 10.32.02.10. Under this matrix, the maximum penalty for violation of section 14-404(a)(22) of the Health Occupations Article is revocation of the Respondent's license, and the minimum penalty is a reprimand. The maximum fine for violation of this section is $50,000.00, and the minimum fine is $5,000.00.

Under this matrix, the maximum penalty for violation of section 14-404(a)(40) of the Health Occupations Article is suspension of the Respondent's license for one year, and the minimum penalty is a reprimand. The maximum fine for violation of this section is $50,000.00, and the minimum fine is $2,500.00.

The Board's regulations also identify mitigating and aggravating factors for imposing a penalty outside of the regulatory range. Mitigating factors include:

> (a) The absence of a prior disciplinary record;
> (b) The offender self-reported the incident;
> (c) The offender voluntarily admitted the misconduct, made full disclosure to the disciplinary panel and was cooperative during the disciplinary panel proceedings;
> (d) The offender implemented remedial measures to correct or mitigate the harm arising from the misconduct;
> (e) The offender made good faith efforts to make restitution or to rectify the consequences of the misconduct;
> (f) The offender has been rehabilitated or exhibits rehabilitative potential;
> (g) The misconduct was not premeditated;
> (h) There was no potential harm to patients or the public or other adverse impact; or
> (i) The incident was isolated and is not likely to recur.

COMAR 10.32.02.09B(5).

Aggravating factors may include, but are not limited to, the following:

(a) The offender has a previous criminal or administrative disciplinary history;
(b) The offense was committed deliberately or with gross negligence or recklessness;
(c) The offense had the potential for or actually did cause patient harm;
(d) The offense was part of a pattern of detrimental conduct;
(e) The offender committed a combination of factually discrete offenses adjudicated in a single action;
(f) The offender pursued his or her financial gain over the patient's welfare;
(g) The patient was especially vulnerable;
(h) The offender attempted to hide the error or misconduct from patients or others;
(i) The offender concealed, falsified or destroyed evidence, or presented false testimony or evidence;
(j) The offender did not cooperate with the investigation; or
(k) Previous attempts to rehabilitate the offender were unsuccessful.

COMAR 10.32.02.09B(6).

In this case, the Board seeks to impose the following disciplinary sanctions:

- A reprimand;

- Two years probation;

- Supervision by a physician licensed in family medicine for one year by a physician recommended by the Respondent and approved by the Board;

- That the Respondent meet with the approved supervisor once a month to go over ten patient records selected by the supervisor;

- That the approved supervisor provide quarterly reports to the Board regarding the Respondent's deficiencies and his progress in addressing those deficiencies;

- That the Respondent take a course in medical care record keeping that is not on-line, and that will not count to fulfill any continuing education credit toward renewing a medical license, and;

- That the Respondent pay all costs related to the sanctions.

In this case, the Board is not seeking a fine.

III. Arguments of the Parties

The Board argued that it gathered records for review by peer reviewers who opined, following their review, that the Respondent failed to meet the standard of care for quality medical care for nine of eleven patients reviewed because he prescribed antibiotics to patients with negative strep tests, failed to take any vital signs, failed to adequately document patients' histories of present illnesses, failed to conduct adequate physical examinations, failed to document the locations of injuries, and failed to document his medical rationale for the chosen plan of treatment.

The Board argued the Respondent's medical records appear to be canned, and pointed to similarities in the "objective" entries for several of the records reviewed. It argued the Respondent failed to maintain adequate medical records, which would prevent another physician from providing continuity of care to a patient based on the content of those records.

In support of its position the Board cited Board *of Physician Quality Assurance v. Mullan*, 381 Md. 157, 173 (2004), in which the Court observed that the heart of fact-finding is drawing inferences from facts. It argued the inferences to be drawn here are clear.

The Respondent argued the Board failed to prove any of the charges. He argued he is not aware of any law or regulation that requires him to interrupt his day to provide patient records to a patient who does not call ahead to request them and just shows up at his office without an appointment. The Respondent argued that despite Dr. [redacted]'s views as to the adequacy of his pre-surgical examination and report for Patient 7, the surgeon performed the surgery so his report was good enough for the person who mattered most – the surgeon. The Respondent argued Patient 7 is an outlier who is not representative of his patients. He testified he treats the ill and injured without appointments regularly and is well aware of the appropriate standard of care for all the patients he sees.

IV. Expert Witness

The Board called one of the peer reviewers, Dr. [redacted], who is board certified in family medicine, and offered him as an expert in family medicine and urgent care. The Respondent objected to accepting Dr. [redacted] as an expert in these fields.

On the issue of expert testimony, the Court of Appeals has held: "The premises of fact must disclose that the expert is sufficiently familiar with the subject matter under investigation to elevate his opinion above the realm of conjecture and speculation, for no matter how highly qualified the expert may be in his field, his opinion has no probative force unless a sufficient factual basis to support a rational conclusion is shown." *Bohnert v. State*, 312 Md. 266, 274 (1988) (social worker's expert testimony that child under age of fourteen was a victim of sexual abuse was inadequately supported and was inadmissible in prosecution for second-degree sexual offense) citing *State, Use of Stickley v. Critzer*, 230 Md. 286, 290 (1962). The Maryland Rules provide: "Expert testimony may be admitted . . . if the court determines that the testimony will assist the trier of fact to . . . determine a fact in issue. In making that determination, the court shall determine . . . whether a sufficient factual basis exists to support the expert testimony." Md. Rule 5-702.

After hearing Dr. [redacted]'s qualifications, I accepted him as an expert in the fields of family medicine and urgent care.

Even though accepted as an expert, an expert opinion may nevertheless be tested for bias. As noted by the Court of Appeals in *Wrobleski v. de Lara*, 353 Md. 509 (1999):

> The professional expert witness advocating the position of one side or the other has become a fact of life in the litigation process. Practicing lawyers can quickly and easily locate an expert witness to advocate nearly anything they desire. In each part of the country, if you need an expert medical witness to state that plaintiff suffered a whiplash injury, call expert X; if you need a medical expert to

> dispute that fact, call expert Y. The use of the expert witness has become so prevalent that certain expert witnesses now derive a significant portion of their total income from litigated matters.

Id. at 515-516. (internal citations omitted). I heard nothing during the hearing to suggest Dr. [redacted] was biased in his views, either in favor of the Board or against the Respondent. He had no apparent interest in the outcome of the hearing, and has no role in determining whether or not the Respondent will be sanctioned. There was no evidence Dr. [redacted] derives a significant amount of his income by testifying as an expert in matters such as the instant case.

I evaluated the evidence and testimony before me, noting that both Dr. [redacted] and the Respondent are more familiar than I with technical, scientific, and medical terms used. I deferred to the expertise of Dr. [redacted] on some issues before me, and relied on his expert opinions as to whether the Respondent failed to deliver appropriate quality medical care, and whether the Respondent failed to keep adequate medical records. I did not adopt his opinions as my own, but rather I determined the extent to which I found his opinions supported by the facts and valuable in my assessment of the evidence. I gave his opinions the weight I determined they deserved. I also considered the extent to which, through his own questioning, the Respondent successfully or unsuccessfully challenged Dr. [redacted]'s opinions.

Dr. [redacted] opined the Respondent failed to provide quality medical care to nine of eleven patients whose records he reviewed, specifically Patients 1, 2, 3, 4, 5, 6, 7, 9, and 10. He opined the Respondent delivered qualify medical care to Patients 8 and 11.

Dr. [redacted] opined the Respondent's medical record keeping was inadequate for all eleven patients whose records he reviewed.

Dr. [redacted] provided the specific factual basis for each opinion expressed. He directed my attention to the specific medical record entries that supported his views, and explained how his professional experience contributed to his opinions.

I found Dr. [redacted]'s testimony persuasive as to the standard of care for delivery of quality medical care as to all patients but one, Patient 7, whose care Dr. [redacted] found inadequate but which I find adequate. I found his testimony persuasive as to the adequacy of the Respondent's medical records except for one patient, Patient 8, whose records Dr. [redacted] found inadequate but which I find to be adequate.

V. The Respondent's Testimony

The Respondent testified he was fighting for his reputation, and suggested eleven records was an inadequate sample from which to conclude sanctions are appropriate.[4] He viewed the Board's case of an exaggeration when none of the patient records reviewed suffered any adverse outcome, and only one of the eleven patients whose records were reviewed complained at all. The Respondent testified he has a very busy solo-physician urgent care practice with a superior level of care, that he provides free care to the homeless, and has never been sued for malpractice. He pointed to his "Best of Bethesda 2018" award for a managed care facility as evidence the community he supports holds him in high esteem. The Respondent testified his practice remains unique in its methods of care and is superior to "big outfits" like Right Time and Patient First.

The Respondent conceded that when interviewed by the Board he told the Board his record-keeping could be better. In large measure the Respondent explains the deficiencies in his

[4] Generally, the Respondent is peeved by the entire Board record review and discipline process. He insists the Board is treating him unfairly based upon one patient complaint, and decried that the Board then chose to call that one complaining patient to testify at the hearing remotely instead of giving him an opportunity to cross-examiner her face to face. He is ardent in his view the Board improperly relied on the reports of "quote-unquote experts" who have less experience than he running an urgent care clinic with a brisk pace and heavy patient load. The Respondent testified the Board's investigation and what followed cost him thousands of dollars in legal fees, and deprived his patients of his care when he attended various preliminary hearings and the merits hearing. He views the entire process as defamatory.

records to the hectic pace of his practice. He testified he understood the risk of over-prescribing antibiotics. In reference to questions about objective findings of "pharynx clear," the Respondent testified that meant the patient's throat was unobstructed. The Respondent said that his insurance billing office selects the billing code for treatment, and if provider notes say "pharyngitis" the billing office bills the visit using the code for "acute pharyngitis." Regarding the "hit by baseball" incident, the Respondent testified the billing office used the billing code for "contusion to face."

VI. Findings as to the Charges

Patient 1, [redacted]

I find the Respondent failed to meet the appropriate standard of care for delivery of quality medical to Patient 1 because a less-than-thorough physical examination of Patient 1 was conducted; Patient 1 complained of a sore throat but there is no evidence the Respondent examined her lymph nodes, and his objective findings include "pharynx clear;" his notes say "Strep +," referencing a throat culture. Finally, he prescribed Amoxicillin to a patient he noted was allergic to penicillin.

I find the Respondent failed to meet the appropriate standard of care for medical record keeping as to Patient 1. His records contain no reference to examination of Patient 1's lymph nodes, and do not comment as to how the Respondent reconciled the inconsistent findings of "Strep +" and "pharynx clear." The Respondent does not comment on how he reconciled his subjective comment of "allergic to penicillin" with administration of Amoxicillin or how he ruled out an allergy to penicillin before prescribing Amoxicillin. On their face these medical records are inconsistent and do not provide a basis for a physician who may next care for Patient 1 to continue her treatment.

Patient 2, [redacted]

I find the Respondent failed to meet the appropriate standard of care for delivery of quality medical to Patient 2 because he did not include vital signs in his examination of Patient 2, did not conduct a lung examination, and prescribed an antibiotic for a sore throat when the throat culture results were negative.

I find the Respondent failed to keep adequate medical records because he did not explain, for the benefit of a future care provider who may undertake Patient 2's care, the medical rationale for prescribing an antibiotic to treat a sore throat when a strep test administered to Patient 2 was negative. The Respondent also failed to record Patient 2's vital signs at the time of the visit, if vital signs were taken.

Patient 3, [redacted]

I find the Respondent failed to meet the appropriate standard of care for delivery of quality medical to Patient 3 because he did not include vital signs in his examination of Patient 3, and his evaluation of Patient 3's objective symptoms was hasty as demonstrated by the cursory fashion in which objective symptoms were recorded.

I find the Respondent failed to keep adequate medical records because he did not record in his notes anything more than "puncture" as his assessment and did not identify the location or severity of the injury. The Respondent also failed to record Patient 2's vital signs at the time of the visit, if vital signs were taken.

Patient 4, [redacted]

I find the Respondent failed to meet the appropriate standard of care for delivery of quality medical care to Patient 4 because he did not did not conduct a lung examination, and he prescribed an antibiotic for a sore throat when the throat culture results were negative.

I find the Respondent failed to keep adequate medical records because he did not explain, for the benefit of a future care provider who may undertake Patient 4's care, the medical rationale for prescribing an antibiotic to treat a sore throat when a strep test administered to Patient 4 was negative.

Patient 5, [redacted]

I find the Respondent failed to meet the appropriate standard of care for delivery of quality medical to Patient 5 because no vital signs were taken, no history of infection was recorded, and the Respondent did not inquire whether Patient 5 may have a cardiac history or may be on a blood thinner before performing an incision and drainage and removal of a foreign body.

I find the Respondent failed to keep adequate medical records because he did not explain, for the benefit of a future care provider who may undertake Patient 5's care, the nature of the foreign body in Patient 5's foot, the method of closure of the wound, and did not include any reference to whether an antibiotic was administered, whether wound care instructions were provided, or whether a tetanus shot was offered or administered.

Patient 6, [redacted]

I find the Respondent failed to meet the appropriate standard of care for delivery of quality medical to Patient 6 because no vital signs were taken, and no evaluation for possible injury to cranial nerves was conducted. The Respondent did not conduct or offer any imaging studies and there is no mention of why such studies, if offered, were not performed. He did not educate Patient 6's parents of the signs of concussion or subdural hemorrhage to watch for.

I find the Respondent failed to keep adequate medical records because he did not explain, for the benefit of a future care provider who may undertake Patient 6's care, the nature or

location of the injury and only wrote "PT hit by baseball" without reference to where Patient 6 was struck. The Respondent did not record whether there was any loss of consciousness, and there are no findings related to his injury other than "contusion."

Patient 7, [redacted]

I find the Respondent met the appropriate standard of care for the delivery of quality care with respect to Patient 7, and thus disagree with Dr. [redacted] as to Patient 7. The Respondent took vital signs, evaluated allergies, evaluated her current medications, reviewed her past medical history, inquired about whether she has past problems with anesthesia, inquired about her family medical history, and did lab work. He cleared Patient 7 for surgery and provided his recommendation and Patient 7's EKG of October 24, 2017 to the surgeon, who apparently was satisfied with the Respondent's evaluation because he performed the surgery.

Dr. [redacted] opined the Respondent failed to meet the standard of care because he was unable to tell from the records what surgery was scheduled. This conclusion relates to medical record keeping. Apparently the Respondent knew the type of surgery planned, as did the surgeon and Patient 7. The Respondent's only role was to determine if there were any medical contraindications for the surgery. And while the Respondent may have requested Patient 7 undergo a new EKG to save time, this request was not unreasonable when Patient 7 did not call ahead to request that the October 24, 2017 EKG be ready, and did not make an appointment for a pre-surgical exam.

I agree with Dr. [redacted] with respect to the Respondent's failure to keep adequate medical records for Patient 7, but only to the extent the Respondent did not record the nature of the surgery for which he was conducting a pre-surgical examination. In Dr. [redacted]'s view, with which I agree, the surgeon must see that the Respondent was aware of the nature of the surgery

to have any confidence in the Respondent's pre-surgical evaluation. Otherwise, I find the Respondent's medical records as to Patient 7 were adequate.

Patient 8, [redacted]

I find (as did Dr. [redacted]) the Respondent met the appropriate standard of medical care for Patient 8. She presented so he could administer an injection of fluphenazine to treat her schizophrenia.

I find the Respondent kept adequate medical records for Patient 8, and thus disagree with Dr. [redacted] on this issue. Although the Respondent took no vital signs, there is no evidence Patient 8 complained of fever or sickness when she presented herself for treatment. The Respondent, or both of two others who worked at the Respondent's clinic, recorded "NAD, ALERT, HEENT, NCAT, EOMI, TRACHEA MIDLINE, PHARYNX CLEAR,CV, NO DISTRESS ABD, NO DISTENTION and EXT, NO EDEMA" as objective assessments. While Dr. [redacted] is of the view these entries are copied and canned to save time – a view clearly supported by the exhibits - there is no evidence the Respondent did not perform these objective assessments or ensure they were performed by those who worked at his clinic.

Patient 9, [redacted]

I find the Respondent failed to meet the appropriate standard for the delivery of medical care for Patient 9 because, when Patient 9 presented with shoulder pain the Respondent did not take any vital signs and the Respondent did not examine Patient 9's shoulder. The Respondent made no mention how Patient 9 was injured, and did not order any imaging. He did not instruct Patient 9 on how to avoid further injury or aggravation.

I find the Respondent failed to keep adequate medical records for Patient 9 because the Respondent did not record any vital signs, did not record any examination of Patient 9's

shoulder, and did not record the results of any imaging, and did not record whether he instructed Patient 9 on how to avoid further injury or aggravation.

Patient 10, [redacted]

I find the Respondent failed to meet the appropriate standard of care for Patient 10 because he failed to thoroughly examine Patient 10's wrist. Patient 10 complained of wrist pain following a car accident and the Respondent did not test Patient 10's muscle strength, reflexes, capillary refill time, or range of movement. The Respondent did not examine Patient 10's wrist for swelling or bruising. The Respondent took no x-ray.

I find the Respondent failed to keep adequate medical records as to Patient 10. There is no reference to testing for muscle strength, reflexes, capillary refill time, or range of movement, and no description of any swelling or bruising. The Respondent's records do not say whether imaging was offered and, if offered, why it was refused.

Patient 11, [redacted]

I find the Respondent met the standard of care for delivery of quality medical care for Patient 11, as did Dr. [redacted].

I find the Respondent failed to keep adequate medical records as to Patient 11 as he failed to document how Patient 11 tore the skin on her arm, and did not describe or detail the nature of the examination of her arm that he performed. There is no mention whether a sterile dressing was applied in conjunction with the dermabond, and no reference to what he told Patient 11 as to wound care after she returned home.

Summary of Findings

I find, for the reasons stated above, that the Board has proven that the Respondent violated the standard of care for delivery of quality of medical care for Patients 1, 2, 3, 4, 5, 6, 9, and 10, as

alleged in the charges. I find, for the reasons stated above, that the Board has not proven the Respondent violated the standard of care for Patient 7, as alleged in the charges.

I find, for the reasons stated above, that the Board has proven the Respondent failed to keep adequate medical records as to Patients, 1 through 7, and 9 through 11, as alleged in the charges. I find, for the reasons stated above, that the Board has not proven the Respondent failed to keep adequate medical records as to Patient 8, as alleged in the charges.

The Respondent habitually recorded " GEN: NAD, ALERT HEENT: NCAT, EOMI, TRACHEA MIDLINE, PHARYNX CLEAR. CV: NO DISTRESS. ABD: NO DISTENTION. EXT: NO EDEMA" as objective findings. This cut-and-paste method in recording such findings is unacceptable as it provides little meaningful information to a physician who may be required to provide follow-up care to the Respondent's patients. This method also suggests a less-than-thorough examination and evaluation of objective findings.

On March 1, 2016, the Board issued an advisory letter to the Respondent in which it warned the Respondent that his objective findings regarding a patient were cursory. It noted the Respondent failed to record vital signs, recorded that the patient was seen for a post-operative visit, but the Respondent did not record what the surgery was, and as objective findings the Respondent recorded: "HEENT; NCAT, EOMI, trachea midline, pharynx clear." The Board also noted its concern the medical record was not electronically signed by the Respondent until six weeks after the patient's visit.

On October 18, 2016, the Board issued an advisory letter in which it warned the Respondent his care of a patient was substandard. It noted the Respondent did not electronically sign the patient's medical record until five weeks after he provided care.

Despite these warnings the Respondent persists in cursory record keeping, and persists in electronically signing medical records weeks, and sometimes months, after seeing the patient. The hectic pace of a solo-physician urgent care practice does not excuse his habits.

For the reasons stated above, I find that the Respondent is subject to disciplinary action under subsections (a)(22) and (a)(40) of the Health Occupations Article.

VII. Mitigating and Aggravating Factors

Here, the following mitigating factors apply:

- The Respondent has no prior disciplinary record; and,
- The Respondent's misconduct was not premeditated.

COMAR 10.32.02.09B(5).

Here, the following aggravating factors apply:

- The offense had the potential for or actually did cause patient harm; and,
- Previous attempts to rehabilitate the Respondent were unsuccessful.

COMAR 10.32.02.09B(6).

Administration of Amoxicillin to a patient allergic to penicillin may have led to extremely adverse consequences.[5] However, no evidence was presented of an adverse consequence for any of the eleven patients whose records were reviewed. Prescribing antibiotics to patients who would not benefit from them is inconsistent with delivery of quality medical care.

The Board presented two advisory letters issued by the Board in 2016, each noting deficiencies in the adequacy of the Respondent's medical record keeping.

I do not find these mitigating or aggravating factors sufficiently mitigating or sufficiently aggravating to warrant a sanction outside the regulatory range of COMAR 10.32.02.10.

[5] Dr. Thaker criticized the Respondent for administering Amoxicillin to a patient allergic to penicillin, and also criticized the dose as inadequate. I attribute this inconsistency to Dr. [redacted]'s general lack of confidence in the content of the Respondent's medical records.

VIII. Appropriate Sanction

The Board seeks a probationary period of two years, which I find too long given that the Respondent's violations are largely attributable to his record keeping and not to his patient care.

I find the evidence supports the following disciplinary sanctions:

- A reprimand;
- Six months probation;
- Supervision by a physician licensed in family medicine for six months by a physician recommended by the Respondent and approved by the Board;
- That the Respondent meet with the approved supervisor once a month to go over ten patient records selected by the supervisor;
- That the approved supervisor provide two reports to the Board, at the three-month mark and at the six-month mark, regarding the Respondent's deficiencies and his progress in addressing those deficiencies;
- That the Respondent take a course in medical care record keeping that is not on-line, and that will not count to fulfill any continuing education credit toward renewing a medical license, and;
- That the Respondent pay all costs related to the sanctions.

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude as a matter of law that the Respondent failed to meet appropriate standards for delivery of medical and surgical care in an outpatient facility as determined by peer review, in violation of section 14-404(a)(22) of the Health Occupations Article, and failed to keep adequate medical records in violation of section 14-404(a)(40) of the Health Occupations Article. Md. Code Ann., Health Occ. §§14-404(a)(22) and 14-404(a)(40) (2014 & Supp. 2019). As a result, I conclude that the Respondent is subject to

disciplinary sanctions of a reprimand with probation, including in-person supervision by a physician to address medical record keeping deficiencies and including a course in medical record keeping. *Id.*; COMAR 10.32.02.09 and 10.32.02.10.

PROPOSED DISPOSITION

I **PROPOSE** that charges filed by the Maryland State Board of Physicians against the Respondent on September 24, 2018, as amended July 24, 2019 to reflect the Respondent's current Board certification status, be **UPHELD,** with the exception that the Respondent did not fail to meet the appropriate standard of care for the delivery of quality care with respect to Patients 7, 8, and 11, and with the exception that the Respondent did not fail to keep adequate medical records as to Patient 8; and

I **PROPOSE** that the Respondent be sanctioned by: a reprimand; probation for six months; supervision by a physician licensed in family medicine for six months by a physician recommended by the Respondent and approved by the Board; that the Respondent meet with the approved supervisor once a month to go over ten patient records selected by the supervisor; that the approved supervisor provide two reports to the Board, at the three-month mark and at the six-month mark, regarding the Respondent's deficiencies and his progress in addressing those deficiencies; that the Respondent take a course in medical care record keeping that is not on-line, and that will not count to fulfill any continuing education credit toward renewing a medical license; and that the Respondent pay all costs related to the sanctions.

October 23, 2019
Date Decision Issued

Michael R. Osborn
Administrative Law Judge

MRO/kdp
181283

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party adversely affected by this proposed decision may file written exceptions with the disciplinary panel of 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 10.32.02.05. Exceptions must be filed within fifteen (15) days of the date of issuance of this proposed order. COMAR 10.32.02.05B(1). The exceptions and request for hearing must be addressed to the Disciplinary Panel of the 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 disciplinary panel 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 10.32.02.05C. The OAH is not a party to any review process.

Copies mailed to:

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