IN THE MATTER OF	*	**BEFORE THE**
LISA HERNANDEZ, RCP	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License No. L06666	*	**Case Number: 2220-0101**

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FINAL DECISION AND ORDER

On January 13, 2021, Disciplinary Panel A of the Board charged Lisa Hernandez, RCP with unprofessional or immoral conduct in the practice of respiratory care and professional, physical, or mental incompetence, in violation of Md. Code Ann., Health Occ. § 14-5A-17(a)(3) and (4). The charges followed a Board investigation based on a Mandated 10-day Report received from a hospital in Baltimore, Maryland (the "Hospital"). The Report stated that Ms. Hernandez resigned from her employment as a respiratory care practitioner prior to being terminated for deficient clinical skills, inappropriate behavior and communication with her coworkers, and overall lack of competence.

An evidentiary hearing was held at the Office of Administrative Hearings on September 21, 22, and 28, 2021. The evidence included witness testimony from two witnesses on behalf of the State and one witness for Ms. Hernandez. In addition, Ms. Hernandez testified on her own behalf. The Administrative Law Judge ("ALJ") also admitted into evidence 11 documentary exhibits offered by the State.

In a Proposed Decision issued on December 10, 2021, the ALJ recommended that the charges issued by Panel A be upheld. As a sanction, the ALJ recommended revocation of Ms. Hernandez's respiratory care license.

Ms. Hernandez filed written exceptions to the ALJ's Proposed Decision and the State filed a response. Both parties appeared before Disciplinary Panel B of the Board for an oral exceptions

hearing on February 23, 2022. After considering the entire record, including the evidentiary record made before the ALJ, the written exceptions, and oral arguments by both parties, Panel B now issues this Final Decision and Order.

FINDINGS OF FACT

Panel B adopts the ALJ's proposed findings of fact numbered 1-71. The Panel also adopts the ALJ's discussion on pages 16-26 of the Proposed Decision. The ALJ's Proposed Decision of December 10, 2021, is incorporated by reference into this Final Decision and Order and is appended to this Order as Attachment A. The facts were proven by a preponderance of the evidence.[1]

Ms. Hernandez was licensed by the Board as a respiratory care practitioner on August 18, 2016. Ms. Hernandez was employed at a hospital in Baltimore, Maryland as a full-time respiratory therapist from the time of her hire on December 12, 2016 until she resigned on August 15, 2019.[2] Ms. Hernandez was hired by her supervisor, who assigned her to work under more experienced respiratory care practitioners, who acted as her preceptors and provided on the job training. The preceptors reported to the supervisor that Ms. Hernandez was having difficulty prioritizing patient care, so her supervisor accompanied her on rounds at the Hospital. The supervisor worked with Ms. Hernandez to give her increased training, and extended her three month orientation period an additional three months, for a total of six months. Ms. Hernandez was sensitive to criticism regarding her work and resistant to counseling from her supervisor.

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[1] Ms. Hernandez argues that the proposed findings of fact are not supported by the evidence and documents in the record. Ms. Hernandez does not give any specific examples of facts that she takes exception to or facts that she alleges are not supported by the record. The panel has reviewed the ALJ's proposed findings of fact and finds that the ALJ's proposed findings are supported by the record. Ms. Hernandez's exception is denied.

[2] The names of hospitals and witnesses are not included in this document and are redacted from the ALJ Proposed Decision to maintain confidentiality.

In August of 2017, the Hospital placed Ms. Hernandez on a performance improvement plan. In December of 2017, Ms. Hernandez received two written reports pertaining to her deficient clinical skills and her inappropriate behavior towards her coworkers. The patient care issues continued throughout 2018 and 2019 and Ms. Hernandez was required to attend the Hospital's Employee Assistance Program for her communication issues, behavior, and unprofessionalism. On February 1, 2019, Ms. Hernandez received her third written warning and was advised that if her communication and clinical skills did not improve, her employment could be terminated.

On August 15, 2019, Ms. Hernandez resigned from her position and the Hospital filed a 10-day report with the Board stating that Ms. Hernandez resigned prior to a pending termination. On August 18, 2019, Ms. Hernandez reported to the Hospital, for the first time, that she was harassed, accosted, and verbally abused by co-workers at the Hospital. After leaving the Hospital, Ms. Hernandez was terminated from three respiratory care therapist jobs in Maryland in 2020 before moving to California.

CONSIDERATION OF EXCEPTIONS

Professional Incompetence

The ALJ found that the record contained overwhelming evidence that Ms. Hernandez was incompetent to practice respiratory care while employed at the Hospital based on her lack of knowledge of the proper care and treatment of patients. Ms. Hernandez argues that the ALJ failed to consider the uncontroverted and undisputed testimony that she has successfully been performing the duties of her job as a respiratory care practitioner in California after she left the Hospital. To that end, Ms. Hernandez asks the Panel to admit a letter from her current employer, labeled as R4 in the record extract attached to Ms. Hernandez's exceptions, pursuant to the Board's regulations which allow for additional evidence during the oral exceptions hearing.

Additional evidence is not permitted through the written exceptions process. COMAR 10.32.02.05B(1)(e). At the oral exceptions hearing additional evidence may be accepted under certain narrow conditions. COMAR 10.32.02.05B(3) provides:

> At the oral exceptions hearing, the disciplinary panel may not accept additional evidence unless:
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> (a) Both parties consent to the admission of additional documentary evidence and the disciplinary panel determines that acceptance of the additional evidence would promote the just and efficient completion of the process; or
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> (b) The disciplinary panel determines that either:
>
> (i) A compelling reason exists that would create an obvious injustice if the additional documentary evidence were not considered and the evidence can be admitted without compromising the rights of the other party, including the other party's opportunity to see the proffered evidence in a timely manner or cross-examine the source of the proffered document and present evidence to the contrary; or
>
> (ii) The evidence has been timely proffered before the administrative law judge and the administrative law judge abused his or her discretion in refusing to admit the evidence.

The State has not consented to the admission of the additional documentary evidence and the evidence was not timely presented to the Administrative Law Judge. The State argues that Ms. Hernandez has not shown a compelling reason for the Panel to consider the new evidence and that admitting the new evidence now would be unfair because the State had no opportunity to perform any cross-examination regarding the documents or present any evidence to the contrary. The Panel agrees that admitting the additional evidence at the exceptions hearing would be unfair because the State did not have the opportunity to question any of Ms. Hernandez's subsequent employers or present any evidence to the contrary. The Panel also agrees that Ms. Hernandez has not shown a compelling reason for the Panel to admit the new evidence. Ms. Hernandez was permitted to testify regarding her subsequent employment in Texas and California and read the letter of reference aloud at the OAH hearing even though the ALJ did not permit the exhibit to be admitted.

The Panel likewise will consider Ms. Hernandez's testimony about her subsequent employment and the content of the letter from her employer, but will not admit the additional document into the record. The Panel accepts Ms. Hernandez's testimony that she is licensed in California and has practiced there without incident, but gives the evidence little weight due to the short duration of her employment and the inability of the State to corroborate the authenticity of the reference and to provide any evidence to the contrary. The ALJ concluded that the State proved its case against Respondent based on the information from the initial Baltimore hospital regardless of her subsequent employment and work performance in California. The Panel agrees and will not admit R4 and R19-33, which were not part of the record at OAH.

Ms. Hernandez also takes exception to the ALJ's conclusion that she failed to improve in her job performance and argues that her evaluations in 2018 noted that she was improving. The State responds that there is overwhelming evidence detailing numerous instances where Ms. Hernandez failed to demonstrate the required knowledge to practice respiratory care safely and that the performance evaluations are inadmissible because they were not part of the record considered by the ALJ at OAH. The performance evaluations for July 1, 2017 - June 30, 2018 and July 1, 2018 - June 30, 2019 are part of the OAH record and the Panel will consider the evaluations. Ms. Hernandez's supervisor testified that Ms. Hernandez started showing improvement after she was placed on a performance improvement plan in 2018, but further testified that Ms. Hernandez's clinical skills plateaued and then regressed. The ALJ found that the supervisor counseled Ms. Hernandez and brought her deficient clinical skills to her attention on numerous occasions, but Ms. Hernandez persisted in incompetently providing care. The supervisor testified that even after Ms. Hernandez attended the Employee Assistance Program, Ms. Hernandez's clinical skills did not reflect sufficient improvement. The Panel recognizes that Ms. Hernandez's clinical skills

somewhat improved, as documented in the performance evaluations, but after considering the totality of the evidence in the record, the Panel concludes that Ms. Hernandez was still deficient in her performance and agrees with the ALJ that she was professionally incompetent in the performance of her clinical duties at the Hospital.

Unprofessional Conduct

Ms. Hernandez does not dispute or take exception to the ALJ's conclusion that she was guilty of unprofessional or immoral conduct in the practice of respiratory care. The ALJ found that Ms. Hernandez regularly exhibited unprofessional conduct in the course of her employment at the Hospital. She was defensive, argumentative, overly sensitive, and extremely rude towards her supervisor and other coworkers. On one occasion, she was scheduled to work a shift at the Hospital and within an hour of the start of the shift, she slipped a note under her supervisor's door stating that she felt sick, and she left the Hospital without telling her supervisor that she was leaving. Hospital policy stated that if an employee was to suddenly become sick, they were required to notify the supervisor that they would not be able to perform the duties of their job. Ms. Hernandez's action in leaving the Hospital without personally notifying her supervisor violated Hospital policy and was highly unprofessional. The Panel adopts the ALJ's discussion and agrees that Ms. Hernandez was guilty of unprofessional conduct in the practice of respiratory care.

Discrimination

Ms. Hernandez takes exception to the ALJ's conclusion that she was never discriminated against by the Hospital. She argues that discrimination was evident based on the fact that the Hospital never initiated an investigation into her complaint of a hostile work environment. The ALJ, however, pointed out that Ms. Hernandez never filed a discrimination complaint with Human Resources during the time she was employed even after being informed that she could do so by

her supervisor. The ALJ considered Ms. Hernandez's testimony that she was discriminated against and the testimony of her supervisor to the contrary. After considering the testimony of both witnesses and Ms. Hernandez's employment file, the ALJ credited the testimony of her supervisor and concluded that the Hospital did not discriminate against Ms. Hernandez. The ALJ noted that the Hospital could have fired Ms. Hernandez long before she resigned based on her documented patient care and unprofessionalism issues, but the Hospital instead extended her probationary status and provided her many opportunities to improve. Even if the allegations of favoritism and hostile work environment were true, they have no bearing on Ms. Hernandez's many clinical deficiencies documented by the Hospital.

Ms. Hernandez also argues that the ALJ improperly discounted the testimony of her witness, a fellow respiratory care practitioner at the Hospital, who testified that the supervisor had favorites and treated employees differently. The ALJ did not find the testimony credible because the witness rarely worked the same shift as Ms. Hernandez and she had little personal knowledge of any of the events described by the supervisor. The co-worker's testimony did not concern events that she observed, but rather was a second-hand recounting from incidents reported to the co-worker by Ms. Hernandez. The Panel adopts the ALJ's credibility determinations and agrees with the ALJ's decision to discredit the testimony. Despite any allegations of favoritism or Ms. Hernandez's assertion that she was being given harder assignments, the weight of the evidence demonstrates that Ms. Hernandez was unable or unwilling to complete the basic tasks of her job. Ms. Hernandez's exception is denied.

CONCLUSIONS OF LAW

Based on the findings of fact and discussion of Ms. Hernandez's exceptions, as set forth above, Disciplinary Panel B concludes that Ms. Hernandez is guilty of unprofessional conduct in

the practice of respiratory care, in violation of Health Occ. § 14-5A-17(a)(3), and professional incompetence, in violation of Health Occ. § 14-5A-17(a)(4).

SANCTION

The ALJ recommended a sanction of revocation. Ms. Hernandez argues that the sanction of revocation was overly severe and not consistent with other cases. She contends that the revocation was not warranted because she continued to show improvement in her clinical skills and in interactions with her peers. The State responds that the Panel should adopt the sanction proposed by the ALJ and revoke Ms. Hernandez's respiratory care license.

The sanctioning guidelines for professional incompetence range from a suspension until professional incompetence is addressed to the Board's satisfaction to a revocation. COMAR 10.32.11.16A(4)(a). The ALJ considered whether to recommend a sanction lower than a revocation and appreciated that a revocation could have a devastating effect on Ms. Hernandez's career and her ability to financially provide for her children. The ALJ declined to recommend a lesser sanction because Ms. Hernandez had already been provided many opportunities to change her behavior and improve her patient care and for whatever reason she was unable or unwilling to do so. The ALJ stated that the overwhelming consideration for the proposed sanction of revocation is that Ms. Hernandez's conduct at the Hospital endangered patient safety on a number of occasions. The Panel agrees with the ALJ that Ms. Hernandez was given numerous opportunities to improve her patient care and her interactions with her colleagues and superiors. Her conduct endangered patient safety and did not substantially improve over time while she was employed at the Hospital. The Panel agrees that revocation is appropriate.

ORDER

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

ORDERED that the license of Lisa Hernandez, RCP, License No. L06666, to practice respiratory care in Maryland is **REVOKED**; and it is further

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

May 3, 2022
Date

Signature on File

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

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 14-5A-17.1, Ms. Hernandez 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 Ms. Hernandez 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:

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

Attachment A

MARYLAND STATE BOARD OF	*	**BEFORE MARY R. CRAIG,**
PHYSICIANS	*	**AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE**
LISA MAVIS HERNANDEZ, R.C.P.,	*	**OF ADMINISTRATIVE HEARINGS**
RESPONDENT	*	**OAH No.: MDH-MBP2-78-21-07703**
LICENSE No.: L06666	*	**MBP CASE No.: 2220-0101A**
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PROPOSED DECISION

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

STATEMENT OF THE CASE

On January 13, 2021, Disciplinary Panel A of the Maryland State Board of Physicians (Board) issued charges (Charges) against Lisa Mavis Hernandez (Respondent), Respiratory Care Practitioner (RCP), for violations of the Maryland Respiratory Care Practitioners Act (the Act). Md. Code Ann., Health Occ. §§ 14-5A-01 to 14-5A-14, 14-5A-16 to 14-5A-25 (2021 Repl. Vol.).[1] Specifically, the Board has charged the Respondent with violating section 14-5A-17(a)(3) unprofessional or immoral conduct in the practice of respiratory care and (4) professional, physical or mental incompetence. Code of Maryland Regulations (COMAR)

[1] All references in this Decision are to the 2021 Replacement Volume. The Charges cite the 2014 Replacement volume and the 2019 Supplement to the Health Occupations Article of the Annotated Code of Maryland. The Act is currently found in the 2021 Replacement Volume. The pertinent Code sections have not been amended since 2019.

10.32.02.03E(3)(d). The disciplinary panel to which the matter 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).

I held a hearing on September 21, 22 and 28, 2021. Health Occ. § 14-405(a); COMAR 10.32.02.04. John M. Singleton, Esquire, represented the Respondent, who was present.[2] Michael Brown, Assistant Attorney General and Administrative Prosecutor, represented the State of Maryland (State).

Procedure is governed by the contested case provisions of the Administrative Procedure Act, the Rules for Hearings Before the Board of Physicians, and the Rules of Procedure of the Office of Administrative Hearings. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2021); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

1. Did the Respondent violate the cited provisions of the applicable law? If so,
2. What sanction is appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

I have attached an Exhibit List to this Decision.

[2] The Respondent attended the first two days of hearing in person and the last day remotely through the Webex video conferencing platform. COMAR 28.02.01.20B(1)(b).

Testimony

The following witnesses testified on behalf of the Board: [redacted] Manager of the Respiratory Care Department and the Sleep Lab at the [redacted]; and [redacted], Director for Respiratory Care Services, [redacted] and [redacted] testified remotely via video through Webex. COMAR 28.02.01.20B(1)(b).

The Respondent testified in her own behalf and presented the testimony of [redacted], a former co-worker.

PROPOSED FINDINGS OF FACT

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

1. At all times relevant to this proceeding, the Respondent was licensed by the Board as an RCP.

2. The Respondent was employed at [redacted] as a full-time Registered Respiratory Therapist from December 12, 2016 until she resigned on August 15, 2019.[3]

3. At the time of her hire, the Respondent had just achieved licensure and had no prior experience as a respiratory therapist.

4. [redacted], the Respondent's supervisor, interviewed the Respondent when she applied for the job at [redacted]. [redacted] knew that the Respondent would require additional training due to her lack of experience, but [redacted] agreed to hire the Respondent because she possessed the required Certified Respiratory Therapist credentials and State license. [redacted] was impressed by the Respondent's enthusiasm to work in the field.

[3] Bd. Ex. 2, p. 78.

5. [redacted] is a teaching institution, and [redacted] has years of experience training new graduates for the requirements of the positions in her department and hospital policies and procedures.

6. When she started work at [redacted], the Respondent completed an orientation about hospital policies and procedures. Next, she was enrolled in a three month departmental orientation program. [redacted] supervised the Respondent during her departmental orientation.

7. During the Respondent's departmental orientation, the Respondent received training on the ventilators used at [redacted] to help patients breathe, the equipment used to administer medications, and the equipment used to check certain values in patients' blood, e.g., oxygen levels and carbon dioxide levels.[4] The Respondent passed all assessments during orientation.

8. As an RCP the Respondent was responsible for monitoring patients on ventilators. The proper exercise of the Respondent's duties is crucial to patient care because ventilators provide life support to patients who require assistance with their breathing.[5]

9. An RCP must know the settings on a respirator, how to verify that the settings match a patient's clinical situation, how to review vital signs, lab work, x-rays to determine the best mode of ventilation, and to make recommendations to other clinical care staff. If an alarm sounds on a respirator, an RCP must respond immediately and be able to respond without assistance.[6]

10. An RCP must know basic oxygen devices, how much oxygen a patient requires, and how to make recommendations to other patient care staff for adjusting oxygen levels.[7]

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[4] Tr. 25.
[5] *Id.*
[6] Tr. 26.
[7] Tr. 28.

11. When she was hired, the Respondent was always assigned to work under the supervision of an experienced RCP acting as her mentor, known as a preceptor. The preceptors provided the Respondent on-the-job training about the duties of her job.

12. The Respondent's preceptors reported to [redacted] that she was having difficulty prioritizing patient care, so [redacted] accompanied the Respondent and her preceptors on rounds at the hospital.

13. [redacted] found that the Respondent did not know the condition of any of her patients in the intensive care unit (ICU).[8] It is important that the RCP know the details of every patient assigned to her so that she can provide appropriate care.[9]

14. While on rounds in the ICU with the Respondent, [redacted] intentionally set off a ventilator patient's alarm to see how the Respondent would respond. A ventilator alarm is an urgent situation requiring immediate attention. The Respondent walked right past the patient without stopping.[10]

15. On another occasion, [redacted] observed the Respondent start to walk into a room occupied by a patient with meningitis without wearing gloves or a mask. Meningitis is airborne and very contagious. The Respondent had not checked the patient's chart, so she was unaware of the meningitis.[11]

16. [redacted] continued to work with the Respondent to improve her skills, and she extended the Respondent's orientation period for three months to a total orientation period of six months.

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[8] Tr. 30.
[9] *Id.*
[10] Tr. 31.
[11] *Id.*

17. [redacted] counseled the Respondent about her work performance on many dates during her early months of employment, including but not limited to June 1, 2017, July 14, 2017, August 15, 2017, August 25, 2017, December 8, 2017, and December 20, 2017.

18. The Respondent regularly resisted [redacted]'s counseling. The Respondent was extremely sensitive to any criticism and became emotional and overly argumentative with [redacted] during the counseling sessions.

19. The Respondent exhibited poor communication skills at [redacted]. She was very argumentative and verbally aggressive at times when she was angry. The Respondent misperceived her preceptors' suggestions to improve her performance as a personal attack.[12]

20. [redacted] counseled the Respondent multiple times about her communication skills, providing her with examples of better ways to communicate.

21. [redacted] has a policy of progressive discipline. First, an employee receives counselling. Next, if there is not satisfactory improvement, the employee receives a first written warning. After that, if the problem performance continues, the employee receives a second and ultimately third written warning. In general, warnings are considered for twelve months from the date issued. The final step is termination of employment.[13]

22. On June 1, 2017, [redacted] issued the Respondent a written warning as a result of an incident in which one of the Respondent's patients had a dangerously low oxygen level and the Respondent failed to notify anyone.[14] [redacted] informed the Respondent that she must notify the appropriate covering clinician whenever a patient's critical vital labs or anything else

[12] Tr. 38.
[13] Tr. 70.
[14] Bd. Ex. 2, p. 81.

affecting a patient's status changes. [redacted] informed the Respondent that failure to do so would result in the Respondent's termination.

23. [redacted] continued to be concerned that the Respondent could pose a risk to patient safety as a result of her deficient clinical skills.

24. On August 4, 2017, [redacted] was observing the Respondent working in the ICU. The Respondent was unable to answer [redacted]'s questions about the Respondent's patients because the Respondent had not reviewed the patients' charts.[15]

25. On August 10, 2017, [redacted] was reviewing patients' charts and noticed that the Respondent did not administer prescribed medication to a patient. The Respondent told [redacted] that she did not see the medication listed in the computer so she sent an email to the hospital pharmacy. [redacted] instructed the Respondent that she should go to the pharmacy and get the medicine.[16]

26. On August 10, 2017, [redacted] met with the Respondent. They discussed the following issues: a situation where the Respondent extubated a patient from a ventilator to a simple face mask instead of an aerosol trach mask in violation of [redacted] protocol; the ICU staff's reluctance to work with the Respondent due to concerns with her clinical skills; and the Respondent's refusal to accept suggestions and instructions from co-workers and [redacted][17]

27. On August 11, 2017, [redacted] wrote an email to the Human Resources Department (HR) expressing her view that the Respondent "may be clinically a danger to our patients because she is not clinically competent."[18]

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[15] Bd. Ex. 1, pp. 51-52.
[16] Bd. Ex. 1, p. 53.
[17] Bd. Ex. 2, p. 40.
[18] Bd. Ex. 1, p. 39.

28. In August 2017, [redacted] placed the Respondent on a performance improvement plan.[19] The Respondent showed improvement in her clinical skills.

29. On December 12, 2017, [redacted] issued the Respondent a Performance Review and Planning Form noting that the Respondent struggled with clinical skills, judgment, and in her interaction with her peers.[20]

30. On December 27, 2017, [redacted] discussed with the Respondent a situation when the Respondent became loud and argumentative with a co-worker because she was assigned to the ICU. The Respondent spoke with [redacted] about it, claiming that she was being discriminated against. [redacted] told the Respondent that the assignment was the result of miscommunication, and she changed the Respondent's assignment to another one. [redacted] told the Respondent that if she felt she was the victim of discrimination then it should be referred to the HR. The Respondent declined to do so.[21]

31. The Respondent never filed a report of job discrimination with HR prior to her resignation.

32. [redacted] issued the Respondent a written disciplinary notice on December 28, 2017 as a result of an unprofessional verbal confrontation the Respondent had with one of her preceptors.[22] Both the Respondent and the preceptor behaved inappropriately, using loud voices and language that is unacceptable at [redacted].[23]

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[19] Bd. Ex. 2, pp. 41-45.
[20] Bd. Ex. 1, p. 72.
[21] Tr. 56-57.
[22] Bd. Ex. 2.
[23] Tr. 74-75.

33. On December 29, 2017, [redacted] and the Respondent again met to discuss the situation and the written warning. The Respondent told [redacted] she had discussed the matter with her mother, who is a nurse, and her mother counseled the Respondent to stop reacting so quickly to problems at work. The Respondent told [redacted] that she was going to take her mother's advice. [redacted] told the Respondent that whenever she felt she was being disrespected at work she could talk to [redacted] anytime. The Respondent told [redacted] she understood and would come to [redacted] with any questions or concerns about her work or her interactions with her co-workers. [24]

34. On January 18, 2018, [redacted] spoke with the Respondent about a patient care issue. The Respondent was caring for a patient in the emergency department whose blood gas results were critical. The Respondent failed to make recommendations to the patient's physician for oxygen adjustments. The Respondent said she was busy caring for other patients. [redacted] told the Respondent that she must prioritize care to critical patients before other patient care duties, an issue which [redacted] had discussed with the Respondent previously. [redacted] told the Respondent that she would not issue a written warning but if this type of error occurred again, the Respondent would receive a written warning.[25]

35. On January 2, 2019, the Respondent took a patient on a ventilator for a CAT scan to the scanning department in the hospital. The Respondent hooked the patient up to a ventilator in the CAT scan waiting room and left the patient there unattended while she returned to the floor to perform routine duties.[26] [redacted] informed the Respondent that she should never leave a patient unattended when the patient is awaiting a test.[27]

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[24] Bd. Ex. 1, p. 22.
[25] Bd. Ex. 1, p. 23.
[26] Tr. 64-65; Bd. Ex. 2, pp. 59-61.
[27] Bd. Ex. 1, pp. 24-25.

36. On January 22, 2019, a patient under the Respondent's care pulled the tube out of her mouth (extubated), disconnecting her access to oxygen. The Respondent was notified of the event but failed to respond for more than thirty minutes. Extubation is an emergency requiring immediate response.[28]

37. [redacted] spoke with the Respondent who stated that it did not take her that long to respond. The Respondent failed to document the incident as required by [redacted] policy. [redacted] counseled the Respondent about required prioritization of patients and the need to document incidents.[29]

38. On January 23, 2019, the Respondent sent [redacted] an email repeating her version of the events and stating that she felt [redacted] threatened her with a written warning.[30]

39. As a result of that email, [redacted] refused to discuss the matter further with the Respondent until HR was involved in the conversation. The Respondent did not initially accept [redacted]'s refusal to discuss the matter, coming to [redacted]'s office and refusing to leave immediately when told to do so.[31]

40. [redacted] required the Respondent to attend the hospital's Employee Assistance Program (EAP) for her communication issues, behavior, and unprofessionalism.[32]

41. The Employee attended the EAP, but her performance in those areas did not improve.[33]

42. On May 27, 2019, the Respondent called the RCP department shortly before the start of her shift asking a co-worker what her assignment would be. Because she was not told

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[28] Tr. 66-67; Bd. Ex. 2, p. 62.
[29] Bd. Ex. 1, p. 27.
[30] Bd. Ex. 1, pp. 23-24.
[31] Bd. Ex. 1, pp. 29-30.
[32] Tr. 67-68.
[33] Tr. 69.

her assignment, the Respondent stated that she was not coming to work. [redacted] spoke with the Respondent and told her that calling out at the last-minute places patient care at risk. The Respondent argued with [redacted], maintaining that she was being disrespected by her co-worker who would not inform her of her assignment. [redacted] told the Respondent that she had to improve her communication skills. The Respondent came to work late and worked her shift.[34]

43. The Respondent texted [redacted] on May 28, 2019 promising to work on controlling her emotions when dealing with workplace issues.[35]

44. On June 19, 2019, [redacted] spoke with the Respondent about a report filed by an Emergency Department nurse about the Respondent's delay in responding to a request to suction a patient. The Respondent did not document the incident as required by hospital policy. [redacted] told the Respondent that her lack of documentation prevented [redacted] from accepting the Respondent's version of the event.[36]

45. RCPs are subject to performing required work any day of the week, including weekends. The process for scheduling RCPs is that the master schedule is posted in advance. The RCPs enter their preferred shifts. Management has the authority to issue a final schedule, taking into account the entries on the master schedule and the RCPs' preferred shifts. At times an RCP may not be granted her preferred shift if it is necessary to provide coverage for patient care.

[34] Bd. Ex. 1, p. 30.
[35] Bd. Ex. 1, p. 30.
[36] Bd. Ex. 1, p. 31.

46. On July 2, 2019, the Respondent called [redacted] complaining about a change in her schedule. [redacted] explained that, although she allows the RCP staff to request shifts on the master schedule, there are times when those requests cannot be accommodated to ensure coverage and protect patient care. The Respondent denied knowing that, and [redacted] reminded her that she sent the Respondent and the other staff multiple emails about changing schedules. The Respondent refused to listen to [redacted] talking over her loudly. [redacted] told the Respondent to stop talking over her. The Respondent continued to do so, and [redacted] hung up on the Respondent.[37]

47. On August 13, 2019, the Respondent learned that [redacted] had scheduled her to work on a weekend. The Respondent approached [redacted] in [redacted]'s office immediately before her scheduled shift to complain about her posted schedule.

48. [redacted] again explained the reasons why she makes the schedule.

49. The Respondent lost her temper and overtalked [redacted], using a loud voice. [redacted] told the Respondent that the conversation was over and asked her to leave the office. The Respondent refused to do so. [redacted] asked her to leave multiple times and when the Respondent refused, [redacted] ordered her out of the office. [redacted] got up to close her door and the Respondent put her foot in the door, preventing [redacted] from closing it. Finally, the Respondent left [redacted]'s office.

50. [redacted] immediately started typing an email to HR, notifying HR what had happened. While [redacted] was attending to her computer, the Employee slid a note under the office door, stating that she suddenly felt ill.[38] The note did not inform [redacted] that the

[37] Bd. Ex. 1, p. 32.
[38] Tr. 89; Bd. Ex. 2, p. 69. The note is illegible. [redacted] read it into evidence.

Employee was leaving work. The Employee never spoke with [redacted] to inform her that she was leaving.

51. [redacted] ultimately noticed and read the note, then left her office and went to talk to nearby staff who told her that the Respondent was very angry, crying, using a loud voice, and throwing things in the department.

52. The Respondent told a co-worker that she was leaving work and the co-worker told the Respondent that it would be considered job abandonment.

53. The policy at [redacted] is that an employee should never come to work sick. If an employee becomes sick during a work shift, the employee must report on her patients to another RCP, inform her supervisor, and then go home.[39]

54. The Respondent was under consideration for termination of her employment on August 15, 2019 as a result of her leaving work without prior notice to her supervisor.

55. [redacted] is the Director of Respiratory Care Services for both [redacted] and the [redacted] main hospital on [redacted] in Baltimore.

56. [redacted] spoke with [redacted] on August 13, 2019 about the events that occurred that day involving the Respondent.

57. The Respondent called and spoke with [redacted] on August 14, 2019 about the prior day's events. [redacted] told the Respondent that leaving prior to the conclusion of her shift and the way she slipped the note under [redacted]'s door was very unprofessional. The Respondent wanted to complain to [redacted] about [redacted], but he told her he was not comfortable talking to her about it on the telephone. The Employee asked [redacted] if she was

[39] Tr. 90.

going to be terminated, and he said it had not been determined as of that time as he was speaking with those involved. The Respondent asked [redacted] if she should resign, and he told the Respondent he could not counsel her about that.[40] [redacted] told the Respondent that he was conferring with others about the incident and that the hospital would get back in touch with her after the review.[41]

58. At that time, [redacted] was discussing the situation with [redacted] HR staff, and patient services leadership. The Respondent was being evaluated for termination based on her leaving work on August 13, 2019 at the beginning of her shift without notice to [redacted]. This could negatively affect patient care because it did not afford the hospital sufficient time to bring in another RCP to provide patient care.[42] [redacted] also considered the Respondent's prior record of corrective action.[43]

59. On August 15, 2019, the Respondent emailed [redacted] resigning her job, effective immediately.[44]

60. On August 15, 2019, [redacted] filed a 10-Day Report with the Board, informing the Board that the Respondent resigned her job at [redacted] "prior to pending termination."[45]

61. On August 18, 2019, the Respondent sent [redacted] an email alleging that she was constantly harassed, accosted, and verbally abused by co-workers at [redacted].[46] This was the first time this information was brought to [redacted]'s attention.[47]

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[40] Tr. 108-109.
[41] Tr. 117.
[42] Tr. 110.
[43] Tr. 145-146.
[44] Tr. 111.
[45] Bd. Ex. 1.
[46] Bd. Ex. 4.
[47] Tr. 114.

62. The Respondent was employed at [redacted] from March 15, 2019 until her employment was terminated on February 23, 2020.[48]

63. The Board subpoenaed the Respondent's personnel records from [redacted] on August 6, 2020.[49]

64. The Employee worked as an RCP at [redacted] from October 14, 2019 until January 8, 2020, when her employment was terminated during her probationary period.[50]

65. The Board subpoenaed the Respondent's personnel file from [redacted] on October 28, 2019.[51]

66. The Respondent was employed by [redacted] from March 2, 2020 until April 29, 2020 when her employment was terminated during her probationary period.[52]

67. The Respondent submitted a letter of resignation to [redacted] on May 1, 2020.

68. The Board subpoenaed the Respondent's personnel file from [redacted] on August 6, 2020.[53]

69. The Respondent was employed by [redacted] from March 13, 2020 until her employment was terminated on June 10, 2020 during her probationary period.[54]

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[48] Bd. Ex. 16.
[49] *Id.*
[50] Bd. Ex. 9, pp. 1, 10.
[51] Bd. Ex. 9, p. 1.
[52] Bd. Ex. 15.
[53] Bd. Ex. 15, p. 1.
[54] Bd. Ex. 12, p. 7.

70. The Board subpoenaed the Respondent's personnel records from [redacted] on August 6, 2020.[55]

71. The Respondent moved to California and currently holds a license to practice as an RCP in that State.

DISCUSSION

Burden of Proof

When not otherwise provided by statute or regulation, the standard of proof in a contested case hearing before the OAH is a preponderance of the evidence, and the burden of proof rests on the party making an assertion or a claim. Md. Code Ann., State Gov't § 10-217 (2021); COMAR 28.02.01.21K. To prove an assertion or a claim by a preponderance of the evidence means to show that it is "more likely so than not so" when all the evidence is considered. *Coleman v. Anne Arundel Cty. Police Dep't*, 369 Md. 108, 125 n.16 (2002). The State bears the burden to show by a preponderance of the evidence that the Respondent is guilty of the Charges. COMAR 28.02.01.21K(1)-(2)(a).

Statutory Violations Charged

The grounds for suspension or revocation of a license under the Act include the following:

> a) Subject to the hearing provisions of § 14-405 of this title, a disciplinary panel, on the affirmative vote of a majority of a quorum of the disciplinary panel, may deny a license to any applicant, reprimand any licensee, place any licensee on probation, or suspend or revoke a license, if the applicant or licensee:
> . . .
> (3) Is guilty of unprofessional or immoral conduct in the practice of respiratory care; [or]
> (4) Is professionally, physically, or mentally incompetent[.]

Health Occ. § 14-5A-17(a)(3) & (4).

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[55] Bd. Ex. 12, p. 2.

Positions of the Parties

The State argues that the Respondent's license to practice respiratory therapy should be revoked for the following reasons. The Respondent came to the Board's attention in August 2019 when the Board received a 10-Day Report from [redacted]. The report indicated that the Respondent had a disagreement with [redacted], her supervisor, about her schedule. After a disagreement with [redacted], the Respondent slipped a note under her office door and left the hospital without permission or arranging for the care of her patients. This placed her patients (some of whom were on ventilators) in significant jeopardy.

In addition, the State argues, the Respondent had a history of clinical deficiencies and problem communications. The hospital gave the Respondent many opportunities to improve her performance and communications, but she did not show sufficient improvement. The hospital was in the process of terminating the Respondent's employment when she submitted her resignation.

The State points out that the Respondent went on to work at four other health care institutions. At each place her employment was terminated after a short time for similar reasons. Taken together, the State argues, the evidence shows that the Respondent is guilty of unprofessional behavior and professional incompetence.

The Respondent disputes many of the State's facts. She contends that the argument with [redacted] was justified because [redacted] added two twelve-hour shifts to her schedule on short notice. After their argument went on for some time, [redacted] asked her to leave the office. The Respondent felt ill, so she left the hospital after slipping a note under [redacted]'s door. The Respondent talked with [redacted]. He suggested that she resigned, so she did. The

Respondent did not know that the hospital would report her to the Board after she quit her position.

The Respondent feels that as a new graduate, she was not provided the on-the-job training she needed to do a good job. According to the Respondent, her preceptors did not like her. The Respondent believes [redacted] discriminated against her. When complaints were brought to [redacted]'s attention by the Respondent's preceptors, she accepted them at face value and did not have them investigated by a neutral third party. In addition, the Respondent believes that she was treated unfairly in job assignments by receiving harder assignments than other RCPs on her shifts. The Respondent contends that she fulfilled all the responsibilities of her job at [redacted].

For the following reasons, I conclude that the Board met its burden of proving the Charges.

Respondent's Clinical Skills

The evidence is comprehensive and overwhelming that the Respondent was incompetent to practice respiratory therapy throughout her employment at [redacted]. The record contains many contemporaneously documented examples of the Respondent's lack of knowledge of the proper care and treatment of patients. These instances are listed in the above findings of fact and will not be repeated here.

[redacted] was the Respondent's supervisor throughout the Respondent's employment at [redacted]. [redacted] was a patient, attentive, supportive supervisor to the Respondent. [redacted] knew the Respondent was a new graduate when she interviewed her, but she decided to hire the Respondent because during her interview, she demonstrated a positive attitude and a desire to learn.

[redacted] made certain that the Respondent received on-the-job training during her three-month initial orientation period from more experienced RCPs whom [redacted] assigned to work with and instruct the Respondent. When [redacted] heard from the preceptors and other [redacted] clinical staff of their concerns about the Respondent's abilities, [redacted] went on rounds with the Respondent. In that way, [redacted] obtained first-hand knowledge of the Respondent's poor clinical skills. One particularly striking example is the time when [redacted] purposely set off a patient's ventilator alarm to see what the Respondent would do. The Respondent did not respond to this urgent warning.

Another example witnessed by [redacted] occurred when the Respondent almost walked into a patient's room without protective equipment because the Respondent failed to check the patient's chart. If she had checked, the Respondent would have learned that the patient had a highly contagious airborne disease. Throughout her employment the record shows that the Respondent did not know her patients because she did not read their charts before providing patient care. This is a serious lapse of the duties of an RCP. [redacted] brought this deficiency in clinical skills to the Respondent's attention on numerous occasions, but the Respondent persisted in incompetently providing patient care.

[redacted] could have justifiably recommended the Respondent's termination during her probation, but instead she chose to give the Respondent a chance to improve by extending her probation. Furthermore, when events occurred later, [redacted] referred the Respondent to the EAP for help and placed her on a performance improvement plan. A review of the Respondent's last eight months at [redacted] indicates a persistent, serious breach of patient care protocols by the Respondent despite these attempts to assist her to improve her clinical skills.

In January 2019, the Respondent left a patient requiring ventilation support alone to wait for a CAT scan while the Respondent attended other patients. Later that month, the Respondent failed to respond promptly to a call that a patient had pulled her breathing tube out and it needed the Respondent's skill to replace it to support the patient. In June 2019, the Respondent failed to report to a nurse's call to assist a patient who required suctioning of secretions to allow the patient to breathe. At this point in her tenure, the Respondent had received counsel from more experienced RCPs and extensive supervision by [redacted], but she remained unable to perform the functions of her position. The Respondent was professionally incompetent to perform the duties of an RCP at [redacted]. Her incompetence placed many patients at serious risk of harm.

[redacted] testified clearly, calmly and in great detail about the Respondent's deficiencies. She was subject to thorough cross-examination by [redacted] and did not waver or contradict herself. I did not detect any bias, evasion, or exaggeration in her important testimony. There were numerous contemporaneous notations made by [redacted] of counseling she conducted one-on-one with the Respondent in her office. [redacted] was supportive of the Respondent and her efforts to learn the requirements of her profession. One example was when the two had a fairly contentious discussion about the Respondent's performance, and the next day the Respondent told [redacted] that she was going to take her mother's advice and be more open to constructive criticism and stay calm. [redacted] supported that goal and offered her open door to the Respondent for any future problems.

The Respondent testified, refusing to acknowledge any deficiencies in her performance. She testified that [redacted] treated her unfairly and bullied her. The Respondent's defensive, somewhat combative testimony totally failed to address the specific clinical deficiencies enumerated by [redacted]'s testimony and corroborated by [redacted]'s contemporaneous notes

and the Respondent's personnel file. The Respondent did not testify about each of the specific instances documented by [redacted]. I found the Respondent's testimony evasive, inconsistent with the documents, and wholly inadequate to refute the State's evidence.

The Respondent testified that she was discriminated against by [redacted]. [redacted] denied the allegation. I did not find any evidence of discriminatory treatment. On the contrary, the undisputed record shows that the Respondent was given an extended probationary period, access to the EAP, and many meetings with [redacted] during which the Respondent was allowed to provide her explanation of events. The Respondent never filed a discrimination complaint with HR, even though [redacted] told her that HR would accept such a complaint.

It could be argued that [redacted] would have been justified in terminating the Respondent's employment years before the Respondent resigned, but [redacted] gave the Respondent many chances to improve her performance. The Respondent was never demoted or suspended. I conclude that [redacted] did not discriminate against the Respondent. The Respondent is making that allegation now as a disingenuous shield against the mountain of evidence of her professional incompetence.

The Respondent's witness, [redacted], testified that the Respondent was treated unfairly by [redacted]. She stated that [redacted] had favorites who were given easier assignments and allowed to watch television while on duty whereas the Respondent was given harder assignments such as the ICU. I did not find [redacted]'s testimony credible. She rarely worked on the same shift as the Respondent and had little personal experience with any of the situations documented in the record. Some of those incidents were alarmingly dangerous to patients, yet the witness never addressed them or indicated any concerns for patient safety.

Everything she purported to know about the Respondent's treatment at [redacted] she learned from the Respondent. I gave her testimony no weight.

For all these reasons, I conclude that the Respondent was professionally incompetent in her job at [redacted].

Respondent's Communication and Inter-personal Skills

The record contains substantial, reliable evidence that the Respondent regularly exhibited unprofessional conduct in the course of her employment at [redacted]. The Respondent was defensive, argumentative, overly sensitive, and extremely rude toward [redacted] and her co-workers. I have made findings of fact about the many occasions when the Respondent was loud when speaking with others, would not even listen when others were speaking, and refused to accept constructive criticism. The Respondent's conduct toward others was totally contrary to an atmosphere of quiet professionalism necessary to support patient care. A hospital is a high stress working environment. After all, patients who are hospitalized are seriously ill or they would not have been admitted. An RCP cannot maintain an environment of calm professionalism if she is yelling at others and talking over people. This type of conduct imperils optimum patient care because it might upset a patient, and it certainly has the potential to distract other medical professionals from their duties.

[redacted], who presented her testimony in a calm, thoughtful manner, described one telephone conversation when the Respondent yelled at her, talked when [redacted] was speaking, and refused to listen. [redacted] was forced to hang up the phone.

The last incident in [redacted]'s office was horribly unprofessional. The Respondent complained about her schedule, [redacted] listened, and then gave the Respondent an explanation of the reasons for her assignment. Unless the hospital agrees to a guaranteed

schedule, RCPs are expected to cover shifts as necessary to ensure that all patients receive necessary care. [redacted] allowed the RCPs to select their shifts on a tentative schedule, but every preferred shift cannot be accommodated. The uncertainty generated by the requirements of this job certainly can cause havoc in an employee's personal life. The Respondent lost her temper, raised her voice with [redacted], and refused to leave the office, even putting her foot in the door to prevent [redacted] from closing it. This insubordinate, rude behavior was extremely unprofessional. Unfortunately, it might have been the most flagrant example, but it was not the only instance of unprofessional conduct documented in the record.

After this argument with [redacted], the Respondent was emotionally out of control. She was scheduled to work a shift within the hour, but she was so angry that she slipped a note under [redacted]'s door stating she felt sick. The note did not inform [redacted] that the Respondent was leaving the hospital and not working her assigned shift. [redacted] found the note and learned from others in the department that the Respondent abandoned her job that day.

This conduct was unprofessional and a violation of [redacted] policy. If the Employee became suddenly sick at work, she was required by hospital policy to speak with [redacted]. The Employee testified that she got a headache and high blood pressure as a result of the argument with [redacted]. Even if that is true, the Respondent did not explain why she left without speaking with [redacted].

The hospital and patients were placed at risk of harm by the Respondent's behavior. [redacted] testified that if [redacted] learns in advance that an RCP is unable to work a scheduled shift, it can often obtain a temporary replacement RCP from a staffing agency or ask another employee to work an extra shift. That is impossible if an employee fails to work on short notice.

For all these reasons, I conclude that the State proved that the Respondent was unprofessional in her conduct while employed at [redacted]

Respondent's Post-[redacted] Employment

The State introduced evidence that the Respondent was employed by a number of health care institutions after she left [redacted] and terminated from each job. Her personnel files were obtained through Board subpoenas and admitted into evidence without objection from [redacted]. The Board argued that the files showed a continued pattern of unprofessional and/or incompetent performance by the Respondent.

I have not considered these records in reaching my decision for two reasons. First, in most instances, the Respondent was terminated during her probationary period. Such terminations occur for a variety or reasons, including the likelihood that the terminated employee will have no legal recourse; hence, no risk of liability to the employer. I did not have the ability to listen to a witness explaining if the Respondent was incompetent or unprofessional in her short tenure with the subsequent employers.

Second, and more importantly, I have concluded that the State proved its case based on the wealth of evidence about the Respondent's time at [redacted]. It is simply unnecessary for me to consider files documenting her subsequent performance. Doing so might lead the Respondent to believe that she was treated unfairly in this proceeding since she was unable to confront anyone from her subsequent jobs to challenge what is contained in the files. It is important that this proceeding be conducted with fairness to all parties. On balance, I conclude that disregarding the personnel records of subsequent employment enhances that goal while not impairing the Board's ability to prove its case.

The 10-Day Report

The Board became aware of the Respondent's potential license violations when [redacted] filed a 10-Day Report.

The law requires the report as follows:

> Except as provided in subsections (b) and (d) of this section, hospitals ... shall file with the Board a report that the hospital ... terminated any licensed respiratory care practitioner for any reasons that might be grounds for disciplinary action under § 14-5A-17 of this subtitle.

Health Occ. § 14-5A-17(a).[56]

[redacted] testified that he notified the Board because the Respondent resigned when she was under consideration for termination for unprofessional and incompetent conduct. He further testified that, in trainings conducted by the Board for hospital personnel, he learned that the Board takes the position that a hospital should file a report if there is any question about whether a report is required by law and leave the issue of whether an investigation is warranted to the Board.

The Respondent argued that the 10-Day Report was filed in error because she had not been terminated as of the date when it was filed. I conclude that the Respondent asked [redacted] if she was being terminated and he did not give her an answer or provide any advice about whether it would be better for her to resign before she was terminated. The Respondent did not seek dismissal of the Charges on this ground. I presume the argument is that, without the 10-Day Report, the Board would have never learned of the Respondent's difficulties at [redacted] or opened an investigation.

[56] The law was amended after the date of the August 15, 2019 10-Day Report. Those amendments are inapplicable to this case.

I conclude that it is immaterial to my decision whether [redacted] was required to file the 10-Day Report. The law requires hospitals to file the report so that the Board may have prompt information about conduct that might warrant an investigation. The report does not establish a violation of the licensing statute; it is for Board informational purposes only. After investigation, the Board may file charges and seek disciplinary action against a licensee. Sanctions may not be imposed until a licensed RCP has been afforded an opportunity for an administrative hearing.[57]

Sanction

In this case, the Board seeks to impose the disciplinary sanction of revocation. Health Occ. § 14-5A-17; COMAR 10.32.02.09. The Respondent contends that no violation was proven and, therefore, no sanction is warranted.

I have explained above the many instances of unprofessional and incompetent behavior exhibited by the Respondent during her employment at [redacted]. This persisted despite continuous training, counseling, an EAP referral, written warnings, and the enduring professional guidance of her supervisor. The Respondent has demonstrated through her actions that she is unable to comply with the requirements of her profession.

I am mindful that the Respondent is a single mother who has succeeded in obtaining the necessary education through diligence and persistence in the face of personal challenges in order to pursue licensure and a career as a respiratory therapist. Loss of her license will dash all her hopes for that career and have a devastating effect on her ability to provide for herself and her children. I considered whether a lesser sanction such as a fine, suspension, anger management, or counseling would be appropriate. I decline to recommend those sanctions because the Respondent was already provided many opportunities to change and a lot of counseling from [redacted]. For reasons that are not clear to me, the Respondent was unable or unwilling to respond

[57] *See* Health Occ. § 14-5A-17(b).

to those measures. The Respondent is incapable of dealing with the stress of caring for seriously ill patients and unable to accept constructive criticism with equanimity.

The overwhelming consideration is that the Respondent's conduct at [redacted] endangered patient safety on a number of occasions. Disregarding an alarm alerting an RCP that a patient requiring life sustaining respiratory support is in danger is a stark example of the potential harm to patients. The risk that the Respondent's continuation of her course of conduct might harm a patient is an unacceptable price to pay for affording the Respondent the opportunity to pursue her chosen career. I propose that the proper sanction is revocation of the Respondent's license.

PROPOSED CONCLUSION OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude as a matter of law that the Respondent violated the alleged provisions of the law. Md. Code Ann., Health Occ. § 14-5A-17(a)(3) & (4) (2021). As a result, I conclude that the Respondent is subject to the disciplinary sanction of license revocation for the cited violations. *Id.*; COMAR 10.32.02.09.

PROPOSED DISPOSITION

I **PROPOSE** that Charges filed by the Maryland State Board of Physicians against the Respondent on January 13, 2021 be **UPHELD**; and

I **PROPOSE** that the Respondent be sanctioned by revocation of her license.

Mary R. Craig

December 10, 2021
Date Decision Issued

Mary R. Craig
Administrative Law Judge

MRC/emh
#195565

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) (2021); 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 (2021); COMAR 10.32.02.05C. The OAH is not a party to any review process.

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