IN THE MATTER OF						*	BEFORE THE						
RONNIE TAYLOR, Radiographer						*	MA	MARYLAND STATE					
Respondent						*	BOA	BOARD OF PHYSICIANS					
License Number: R04361						*	Case Number: 2219-0155						
*	*	*	*	*	*	*	*	*	*	*	*	*	

## ORDER OF DEFAULT

On February 20, 2020, Disciplinary Panel B of the Maryland State Board of Physicians ("Board") charged Ronnie Taylor, Radiographer, with unprofessional or immoral conduct in the practice of radiography; professional, physical, or mental incompetence; and failure to cooperate with a lawful investigation conducted by the Board or a disciplinary panel. *See* Md. Code Ann., Health Occ. § 14-5B-14(a)(3), (4), and (26) (2014 Repl. Vol. & 2019 Supp.). On June 5, 2020, the case was referred to the Office of Administrative Hearings ("OAH") for an evidentiary hearing.

On June 12, 2020, OAH mailed a Notice of Scheduling Conference to Mr. Taylor and the State, at their respective addresses of record, notifying the parties that a telephone scheduling conference would be held on June 23, 2020, at 9:30 a.m. The telephone conference scheduling instructions mailed with the Notice stated that the Administrative Law Judge ("ALJ") would call the parties at 9:30 a.m. to commence the conference and listed the phone numbers on file for Mr. Taylor and the administrative prosecutor. The Notice and instructions mailed to Mr. Taylor were not returned as undeliverable. On June 23, 2020, at 9:30 a.m., the ALJ made several attempts to contact Mr. Taylor, but Mr. Taylor did not answer the phone. The ALJ then contacted the administrative prosecutor, who answered the phone call, and appeared on behalf of the State. The ALJ confirmed that there was no request for postponement or other communication from Mr. Taylor received at the OAH and then held the scheduling conference in Mr. Taylor's absence.

On June 24, 2020, a scheduling order was issued, notifying the parties of the date, time, and location of the prehearing conference, among other things. The scheduling order was mailed to both parties at their addresses of record and the copy mailed to Mr. Taylor was not returned as undeliverable. The scheduling order informed the parties that the ALJ's administrative assistant would contact the parties one week prior to the prehearing conference scheduled for July 28, 2020, at 9:30 a.m., and confirm whether the prehearing conference would be held in person or via Google Meet due to the COVID-19 pandemic.

On June 25, 2020, two notices for the prehearing conference were mailed to the parties at their addresses of record. The notices were not returned to the OAH as undeliverable. The first notice informed the parties that the prehearing conference would be held in person at the OAH in Hunt Valley, Maryland. The second notice stated that the prehearing conference would take place via Google Meet and provided the procedures and guidelines for participating in the video conference. Both notices instructed the parties to prepare and submit a prehearing statement no later than 15 calendar days prior to the prehearing conference. Finally, the notices informed the parties that the failure to attend the July 28, 2020 prehearing conference could result in a decision against the party for failing to appear.

On July 10, 2020, the ALJ's administrative assistant sent an email to the parties informing them that the July 28, 2020 prehearing conference would be conducted by Google Meet, and that the parties did not have to appear in person. Neither email was returned as undeliverable.

On July 28, 2020, at 9:30 a.m., the ALJ initiated the Google Meet video platform call to begin the prehearing conference. Mr. Taylor did not appear for the video conference or in person at the OAH, and no one appeared on his behalf. The administrative prosecutor appeared via Google Meet on behalf of the State. The ALJ confirmed that Mr. Taylor had not requested a

postponement of the prehearing conference and that Mr. Taylor had not submitted a prehearing statement, as instructed. After waiting fifteen minutes for Mr. Taylor to appear, and after trying to reach Mr. Taylor by telephone without success, the ALJ proceeded to hold the prehearing conference in Mr. Taylor's absence. The State moved for a default judgment against Mr. Taylor.

Under OAH's rules of procedure, "[i]f, after receiving proper notice, a party fails to attend or participate in a prehearing conference, hearing, or other stage of a proceeding, the judge may proceed in that party's absence or may, in accordance with the hearing authority delegated by the agency, issue a final or proposed default order against the defaulting party." COMAR 28.02.01.23A.

On July 30, 2020, the ALJ issued a Proposed Default Order. The ALJ found that Mr. Taylor had proper notice of the July 28, 2020 prehearing conference and that he failed to appear or participate in the prehearing conference. The ALJ proposed that the Panel find Mr. Taylor in default, adopt as findings of fact the statements set out in the allegations of fact section of the charges, conclude as a matter of law that Mr. Taylor violated Health Occ. § 14-5B-14(a)(3), (4), and (26) in the manner set forth in the charges, and revoke his license to practice as a Radiographer.

The ALJ mailed copies of the Proposed Default Order to Mr. Taylor, the administrative prosecutor, and the Board at the parties' respective addresses of record. The Proposed Default Order notified the parties that they may file written exceptions to the proposed order but must do so within 15 days of the date of the Proposed Default Order. The Proposed Default Order stated that any exceptions and request for a hearing must be sent to the Board with attention to the Board's Executive Director. Neither party filed exceptions. On September 9, 2020, this case came before Disciplinary Panel A ("Panel A") of the Board for final disposition.

#### FINDINGS OF FACT

Because Panel A concludes that Mr. Taylor has defaulted, the following findings of fact are adopted from the allegations of fact set forth in the February 20, 2020 Charges Under the Maryland Radiation Therapy, Radiography, Nuclear Medicine Technology, and Radiology Assistance Act and are deemed proven by the preponderance of the evidence:

Mr. Taylor was initially licensed to practice radiography in Maryland on or about October 12, 1995, under License Number R04361. Mr. Taylor continuously renewed his license but did not renew his license during the most recent renewal cycle. Therefore, his license expired on or about April 30, 2019.<sup>1</sup>

On or about December 21, 2018, the Board received a complaint from a health care staffing agency (the "Agency")<sup>2</sup> that reported that Mr. Taylor had tested positive for an illicit substance during a pre-employment urine drug screen. The Board initiated an investigation into the complaint. As part of its investigation, the Board obtained Mr. Taylor's personnel file from an orthopedic practice in Silver Spring, Maryland (the "Practice"), which was Mr. Taylor's only employer in the previous five years. Mr. Taylor's personnel file showed, in relevant part, that the Practice had terminated Mr. Taylor's employment on or about July 17, 2018. A notice in Mr. Taylor's personnel file revealed that the cause for termination was "misconduct in connection with ... work." The Practice's personnel file for Mr. Taylor included multiple written reports of unprofessional conduct involving Mr. Taylor and directed toward other staff members and patients of the Practice. These incidents included but were not limited to the following:

<sup>&</sup>lt;sup>1</sup> Pursuant to section 14-403 of the Health Occupations Article, the license of an individual regulated by the Board may not "lapse by operation of law while the individual is under investigation or while charges are pending." The Board's investigation began prior to the expiration of Mr. Taylor's license. Therefore, by operation of law, Mr. Taylor's license was not permitted to expire during these proceedings.

 $<sup>^{2}</sup>$  To maintain confidentiality, the names of all witnesses, facilities, employees, and patients will not be used in this document.

- a. On or about August 19, 2014, a physician ("Physician A") approached Mr. Taylor and asked about the status of an x-ray. Mr. Taylor "got up into [Physician A's] face and yelled at him, 'I just sent that to you.'" The Physician was "very upset" and reported to the Office Manager that he had never been spoken to in that way by an employee. Physician A said that if he had originally hired Mr. Taylor, he would have fired Mr. Taylor on-the-spot.
- b. On or about April 24, 2018, a pharmaceutical representative was helping to set up a catered lunch for the Practice's staff. Mr. Taylor entered the room and began to take the food. The representative asked that he wait until all of the food had been set up for staff. Mr. Taylor then "got . . . into her face, yelling 'this is my lunchtime and I will take it when I want.'" Mr. Taylor moved toward the representative so that she was against the refrigerator. The representative was "upset and shaken."
- c. On or about May 14, 2018, a patient complained that Mr. Taylor never introduced himself and then become "irate" and "argumentative" when the patient asked about sanitizing the x-ray table mat. The patient said she did not want to return to the practice to receive treatment.
- d. On or about June 6, 2018, a patient asked Mr. Taylor what his name was, to which he responded, "Don't worry about my name," and "I don't like your attitude, you will be waiting a while." The patient waited "in paper shorts" for over 90 minutes while Mr. Taylor took back other patients who had just arrived for an x-ray.
- e. On or about June 7, 2018, a physician ("Physician B") made a joke to Mr. Taylor about the amount of food on his plate. Mr. Taylor "got very angry and stepped up into [the physician's] face and yelled at him, 'Mind your own business. What I eat is none of your business.'" Physician B wanted to fire Mr. Taylor on-the-spot but deferred to the Office Manager, who convinced Mr. Taylor to apologize.

As part of its investigation, Board staff interviewed several staff members at the Practice. Both Physician A and Physician B confirmed and reiterated Mr. Taylor's unprofessional conduct toward them as described in Mr. Taylor's personnel file (*see* ¶¶ 5a and 5e, *above*). The other interviews revealed the following, among other things:

> f. Physician C explained during his interview that he began working with Mr. Taylor around 2007 when Physician C joined the practice where Mr. Taylor was already working. Physician C said that he noticed that Mr. Taylor become angrier when that practice merged with another in mid-2014, and Mr. Taylor was the only x-ray technician with an increased patient load. Over

time, according to Physician C, he noticed that Mr. Taylor was becoming "so cranky and just not the same happy Ronnie." Physician C, among others, believed in mid-2018 that, because of his worsening attitude and unprofessionalism, it was best for Mr. Taylor to look for other employment outside of the Practice.

g. The Office Manager stated during her interview that Mr. Taylor "started losing his patience" when the two practices merged in 2014, and that he was "not able to control what was coming out of his mouth." The Office Manager said that on one occasion, she was in the kitchen area with other staff members working on an assignment, and Mr. Taylor came in and raised his voice at the Office Manager in front of the other staff members, complaining about his patient load. By mid-2018 and after several outbursts with other staff, the Office Manager and Physician C told Mr. Taylor that the Practice was "no longer a healthy place for [Mr. Taylor] to be."

As part of its investigation, the Board obtained Mr. Taylor's personnel file from the Agency. The personnel file included Mr. Taylor's October 15, 2018 application for the Agency to find placement for Mr. Taylor as a Diagnostic Imaging Technologist. The file also included a report that on or about November 30, 2018, Mr. Taylor tested positive for an illicit substance during a pre-employment drug screen. The report noted that Mr. Taylor was notified and told to contact the Medical Review Officer to discuss confirmation testing. On or about December 12, 2018, the Agency tried to contact Mr. Taylor to follow-up about confirmation testing. According to the report, Mr. Taylor did not respond to the Agency, nor did he submit the necessary paperwork and payment for the confirmation testing. As a result, the Agency never placed him in a position.

On or about July 9, 2019, the Board issued a subpoena to Mr. Taylor for him to appear at the Board on July 23, 2019, for an interview with Board staff. Mr. Taylor did not appear for the July 23, 2019 interview.

On or about July 24, 2019, the Board issued a subpoena to Mr. Taylor for him to appear at the Board on July 29, 2019, for an interview with Board staff. The cover letter to the subpoena also warned Mr. Taylor that failing to appear "could be construed as a failure to cooperate with the Board's investigation." Mr. Taylor did not appear for the July 29, 2019 interview.

By letter dated August 29, 2019, the Board directed Mr. Taylor to appear at a Boardapproved program on September 12, 2019, for an intake evaluation and to schedule a full examination. The Board's letter further advised Mr. Taylor that his failure or refusal to submit to an evaluation would, under Health Occ. § 14-402(c), be *prima facie* evidence of his inability to practice competently. Mr. Taylor did not appear for the September 12, 2019 evaluation.

## CONCLUSIONS OF LAW

Panel A finds Mr. Taylor in default based upon his failure to appear at the OAH for the prehearing conference scheduled for July 28, 2020. *See* State Gov't § 10-210(4). Based upon the foregoing findings of fact, Panel A concludes that Mr. Taylor is guilty of unprofessional conduct in the practice of radiography, in violation of Health Occ. § 14-5B-14(a)(3); is professionally, physically or mentally incompetent, in violation of Health Occ. § 14-5B-14(a)(4); and failed to cooperate with a lawful investigation conducted by the Board or a disciplinary panel, in violation of Health Occ. § 14-5B-14(a)(26).

## SANCTION

Panel A adopts the sanction recommended by the ALJ, which is to revoke Mr. Taylor's license to practice as a radiographer.

## ORDER

It is, on the affirmative vote of a majority of the quorum of Panel A, hereby

**ORDERED** that Ronnie Taylor's license to practice radiography in Maryland (License No. R04361) is **REVOKED**; and it is further

ORDERED that this is a public document. See Health Occ. §§ 1-607, 14-411.1(b)(2) and

# Signature on File

Christine A. Farrelly, Executive Director Maryland Board of Physicians

10/07/2020

Gen. Prov. § 4-333(b)(6).

#### **NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW**

Pursuant to Md. Code Ann., Health Occ. § 14-5B-14.1, Mr. Taylor has the right to seek judicial review of this Order of Default. Any petition for judicial review shall be filed within thirty (30) days from the date of mailing of this Order of Default. The cover letter accompanying this 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 Mr. Taylor 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