

<b>IN THE MATTER OF</b>	*	<b>BEFORE THE</b>
<b>DILSHAD I. KHAN, Radiographer</b>	*	<b>MARYLAND STATE</b>
<b>Respondent</b>	*	<b>BOARD OF PHYSICIANS</b>
<b>License Number: R04432</b>	*	<b>Case Number: 2219-0187A</b>
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**CONSENT ORDER**

On January 30, 2020, Disciplinary Panel A (“Panel A”) of the Maryland State Board of Physicians (the “Board”) charged Dilshad I. Khan, Radiographer (the “Respondent”) with violating the Maryland Radiation Therapy, Radiography, Nuclear Medicine Technology, and Radiology Assistance Act (the “Act”), Md. Code Ann., Health Occ. (“Health Occ.”) §§ 14-5B-01 *et seq.* (2014 Repl. Vol. & 2019 Supp.); Health Occ. §§ 1-201 *et seq.* (2014 Repl. Vol. & 2019 Supp.); and the Board’s sexual misconduct regulations, COMAR 10.32.17.01 *et seq.* (2000).

Specifically, the Respondent was charged with violating the following:

**Health Occ. § 14-5B-14.**

- (a) *In general.* -- Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may . . . reprimand any licensee, place any licensee on probation, or suspend or revoke a license, if the . . . licensee:
  - (1) Fraudulently or deceptively obtains or attempts to obtain a license for the applicant, licensed individual, or for another;
  - (3) Is guilty of unprofessional or immoral conduct in the practice of radiation therapy, radiography, nuclear medicine technology, or radiology assistance;

...

- (10) Willfully makes or files a false report or record in the practice of radiation therapy, radiography, nuclear medicine technology, or radiology assistance[.]

**Health Occ. § 1-212. Sexual misconduct prohibited; regulations; discipline.**

- (a) *Adoption of regulations.* – Each health occupations board authorized to issue a license or certificate under this article shall adopt regulations that:
  - (1) Prohibit sexual misconduct; and
  - (2) Provide for the discipline of a licensee or certificate holder found to be guilty of sexual misconduct.

**Chapter 17 Sexual Misconduct**

**10.32.17.01**

This chapter prohibits sexual misconduct against patients or key third parties by individuals licensed or certified under Health Occupations Article, Titles 14 and 15, Annotated Code of Maryland.

**10.32.17.02**

- A. In this chapter, the following terms have the meanings indicated.
- B. Terms Defined.
  - (2) Sexual Impropriety.
    - (a) “Sexual impropriety” means behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient or a key third party regardless of whether the sexual impropriety occurs inside or outside of a professional setting.
    - (b) “Sexual impropriety” includes, but is not limited to:

- (iii) Using the health care practitioner-patient relationship to initiate a dating, romantic, or sexual relationship[.]
- (3) “Sexual misconduct” means a health care practitioner’s behavior toward a patient, former patient, or key third party, which includes:
  - (a) Sexual impropriety; [or]
  - (c) Engaging in a dating, romantic, or sexual relationship which violates the code of ethics of the American Medical Association, American Osteopathic Association, American Psychiatric Association, or other standard recognized professional code of ethics of the health care practitioner’s discipline or specialty.

**10.32.17.03**

- a. Individuals licensed or certified under Health Occupations Article, Titles 14 and 15, Annotated Code of Maryland, may not engage in sexual misconduct.
- b. Health Occupations Article, §§ 14-404(a)(3) and 15-314(3), Annotated Code of Maryland, includes, but is not limited to sexual misconduct.

On May 13, 2020, Panel A was convened as a Disciplinary Committee for Case Resolution (“DCCR”) in this matter. Based on negotiations occurring as a result of this DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, Order, and Consent.

**FINDINGS OF FACT**

Panel A finds the following:

**I. BACKGROUND/LICENSING INFORMATION**

1. The Respondent was originally issued a radiography license in Maryland on December 19, 1995, under License Number R04432. The Respondent continuously renewed his license. The Respondent's latest license was given the expiration date of April 30, 2021. On January 28, 2020, the Board summarily suspended the Respondent's license.

2. At all times relevant to these charges, the Respondent was employed as a radiographer at various health care facilities in Maryland. The Respondent was employed as a radiographer at a health care facility ("Facility A")<sup>1</sup> in Maryland from 2015 to 2019, when he was terminated for cause. The Respondent was employed as a radiographer at a health care facility ("Facility B") in Maryland from 1999 to 2015, when he resigned in lieu of termination, after an investigation there revealed that he engaged in a pattern of unprofessional and inappropriate behavior. The Respondent was also employed as a radiographer at a health care facility ("Facility C") in Maryland from October 1999 to July 2019, when he was terminated for failing to report that he x-rayed the incorrect body part of an emergency room patient. The Respondent is reportedly now employed as a radiographer at a health care facility ("Facility D") in the Baltimore area.

3. On January 28, 2020, Panel A issued an *Order for Summary Suspension of Radiography License*, in which it summarily suspended the Respondent's Maryland radiography license. Panel A took such action pursuant to Md. Code Ann., State Gov't

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<sup>1</sup> For confidentiality reasons, the names of health care facilities, patients or other individuals will not be disclosed in this document.

(“State Gov’t”) § 10-226(c)(2), concluding that the public health, safety or welfare imperatively requires emergency action.

## **II. THE COMPLAINT**

4. The Board initiated an investigation of the Respondent after receiving a Mandated 10-Day Report (the “Report”), dated May 2, 2019, from Facility A, stating that it terminated the Respondent’s employment after Facility A patients complained that he sexually harassed them while he was providing on-site radiographic services. Facility A recounted two such incidents, occurring in 2018 and 2019, respectively.

5. Facility A reported that in November 2018, a patient (“Patient A”) made a sexual harassment complaint against the Respondent, after which it convened a formal meeting with him where it notified him of its “zero-tolerance” policy against predatory behavior, sexual harassment and unwanted conversations with patients and staff. The Report stated that Facility A imposed an action plan that required the Respondent to undergo sexual harassment training, which the Respondent completed. Facility A informed the Respondent that if it received any further complaints, it would immediately terminate his employment.

6. Facility A reported that on May 2, 2019, another patient (“Patient B”) made a detailed sexual harassment complaint against the Respondent. Facility A noted that the patient was “frightened and visibly shaken” when making her report. Facility A stated that it immediately terminated the Respondent’s employment and escorted him off its premises. Facility A reported that it later examined the Respondent’s workspace computer and discovered “pictures and detailed conversations that were inappropriate in nature. The age

of the women in the pictures was questionable but the pictures and conversations were definitely inappropriate.”

### **III. SUBSEQUENT BOARD INVESTIGATION**

7. The Board conducted an investigation of the Respondent’s conduct at Facility A and other health care facilities that had employed him as a radiographer. The Board’s investigation concluded that the Respondent engaged in acts of unprofessional conduct at health care facilities that included, but were not limited to, sexual harassment/sexual propositioning of patients; sexual harassment and/or assault of a female co-worker; inappropriate computer use; aberrant workplace behaviors; and poor or incompetent provision of radiography services. The Board’s investigation determined that Facilities A and C terminated the Respondent’s employment for behavioral and/or performance issues, and a third health care facility, Facility B, allowed him to resign in lieu of terminating him for similar issues. In addition, the Respondent failed to disclose in his 2017 renewal application that he was under investigation by Facility B for disciplinary reasons and resigned while under investigation for disciplinary issues.

#### **Facility A**

8. The Board’s investigation determined that during the course of the Respondent’s employment at Facility A, a series of female patients alleged that the Respondent sexually harassed and/or propositioned them; and that a female co-worker alleged that he sexually assaulted her in the workplace. These complaints culminated in Facility A’s firing him on May 2, 2019. The Respondent also used his Facility A computer to access sexually-oriented websites where he engaged in on-line chats of a sexual nature.

Although Facility A's Report only noted that the Respondent was the subject of two sexual harassment complaints, its personnel files and the Board's investigation determined that other patients also filed sexual harassment complaints against him.

***Incident occurring on or about October 23, 2018***

9. The first of the two complaints Facility A cited in its Report involved a sexual harassment complaint Patient A filed against the Respondent in November 2018. Patient A complained that during a patient visit, the Respondent "asked if anyone had ever told her she was beautiful and how many times that she was told that."

10. Patient A further reported that the Respondent then "asked if she had any Indian friends and if she or her friends were single." Facility A formally counseled the Respondent for this misconduct, informing him of its "zero tolerance" policy against sexual harassment. Facility A informed the Respondent that if it received any further complaints, it would take disciplinary action against him. Facility A directed the Respondent to take sexual harassment training, which the Respondent completed.

11. After this complaint, Facility A changed its procedures for x-rays to require that a medical assistant be present during all x-ray procedures.

12. Board investigators interviewed Patient A, who stated that she presented to Facility A for a hip x-ray on October 23, 2018, which the Respondent performed. Patient A stated that the Respondent positioned her in a "spread eagle" position for the x-ray, during which he commented on her physical appearance, told her she was "beautiful" and asked her if she had a boyfriend. The Respondent stated that Patient A "should be dating a brown boy." Patient A stated that the Respondent's comments made her feel very

uncomfortable. After the x-ray, Patient A wrote in her journal that the Respondent was “creepy.” Patient A consulted a family member about her experience, after which Patient A reported the incident to staff at Facility A. Because of the Respondent’s actions toward her, Patient A decided to seek medical care elsewhere.

***Incident occurring on or about May 2, 2019***

13. The second incident Facility A cited in its Report involved a complaint Patient B made, alleging that the Respondent sexually harassed and propositioned her when she presented to the office for an ankle x-ray occurring on or about May 2, 2019. During this visit, the Respondent initially began asking Patient B questions about her personal life and complimented her on the color of her toenail polish. Patient B stated that the Respondent’s demeanor was “pretty flirty and forward,” and that her x-ray took “longer than usual.” The Respondent then asked Patient B if she wanted to join him on a family vacation to Disney World along with his wife and children. Patient B strongly and pointedly declined the Respondent’s proposition, despite the Respondent’s insistence. Patient B characterized the Respondent’s remarks as “inappropriate,” “bizarre” and “awkward,” and that he made her feel “uncomfortable.” After the x-ray, the Respondent escorted Patient B into an examination room to wait for her physician when he asked her if she would like to go for a ride in the new car his wife had purchased for him for his birthday. Patient B again declined the Respondent’s proposition, at which point he left the room. The Respondent then re-entered the room, closed the door, whispered her name and asked her not to tell the doctor about their conversation, claiming it was “just a joking matter.” Patient B expressed great concern that the Respondent placed her in a dark room



and propositioned her, which put her in a “compromised position.” After the Respondent left, Patient B immediately reported the incident to Facility A staff. Facility A staff confirmed that Patient B reported the incident, during which the patient was crying and very upset.

14. Facility A immediately fired the Respondent and a Facility A physician escorted the Respondent directly out of the building. Facility A staff then examined the Respondent’s computer and found pornographic material and open on-line chat windows in which the Respondent communicated in a sexual manner with purported women.

15. Board investigators retrieved screen shots confirming the Respondent’s accessing internet dating sites that contained, among other things, photographs of individuals in a state of partial undress and on-line discussions the Respondent had on these sites.

#### ***Other sexual harassment reports***

##### ***Incident occurring on or about April 26, 2019***

16. Facility A’s personnel file indicates that at least one other patient (“Patient C”) reported the Respondent for sexual harassment. On or about May 14, 2019, Patient C reported that when she presented for an x-ray of her arm on April 26, 2019, the Respondent began engaging her in a conversation about her school, after which he told her she was very pretty and “that his son would like a pretty girl.” The Respondent then insistently solicited Patient C to date his son, which made her feel very uncomfortable. Patient C stated that the Respondent insisted on showing her pictures of his son from his cell phone. Patient C further stated that the Respondent told her he knew she was from New York,

which made her very nervous because she did not disclose this information to him. Patient C was concerned that the Respondent was looking through her file and had access to all of her personal information. Patient C stated that the Respondent kept her in the room longer than necessary which made her feel uncomfortable.

***Sexual harassment/assault, 2018***

17. Board staff also interviewed a former Facility A staff person (“Staff Person A”) who reported that the Respondent made sexually inappropriate remarks to her while she was exercising at Facility A on or around June/July 2018. Staff Person A reported the incident, after which the Respondent approached her and told her he was “kidding” and said she was “pretty . . . but [he] didn’t mean any harm.” Staff Person A also reported that in or around October 2018, the Respondent asked her to come into an examination room and lie on the examination table, after which the Respondent laid on top of her. Staff Person A pushed him off, screamed at him and punched him. Staff Person A stated that she reported the incident and avoided the Respondent during the remainder of his tenure there.

***Incident occurring on or about November 10, 2017***

18. Board investigators reviewed internal communications at Facility A that included information from a former Facility A physician who stated that in 2017, a patient (“Patient D”) reported to him that the Respondent asked her out for a date while he was x-raying her. Patient D stated that the Respondent asked her personal questions about where she worked, her family, and whether she wanted to go to a movie with him “some night when her son wasn’t there.” The physician reported concerns that the Respondent “has

pictures of his family and children plastered up everywhere.” The physician stated that Patient D expressed concern about going back for further radiographic studies because of the Respondent’s behavior and presence at Facility A. The physician stated that he mentioned this incident to another Facility A physician who stated that another patient had also made a complaint to him that the Respondent had made inappropriate remarks to her.

19. Board staff interviewed Patient D, who stated that she sustained a shoulder injury after which she presented to Facility A on or about November 10, 2017, for an x-ray. Patient D confirmed that the Respondent took the imaging study, during which he initiated questions about personal matters, at one point asking her, “what do you do for fun?” The Respondent then asked Patient D to go to a movie with him, which she ignored. As Patient D was leaving, the Respondent wrote down his cell phone number on a piece of paper and handed it to her. Patient D left the Respondent and immediately reported the Respondent to a Facility A physician.

20. The Respondent’s personnel file also contains a written memorandum the Respondent signed on March 7, 2017, which recounted that Facility A counseled him for failing to use a shield when taking an x-ray of a patient and using a cell phone during the examination. Facility A stated that “due to [his] negligence and unprofessional behavior,” Facility A “lost a patient and is now subject to negative comments and reviews stemming from this incident.”

### **Facility B**

21. Board staff obtained the Respondent’s personnel file from Facility B, which had employed him as a radiographer from August 23, 1999 to September 16, 2015, when

he resigned his position there in lieu of termination. The Respondent's file states that Facility B had investigated the Respondent for allegations of unprofessional workplace behavior, which included these incidents occurring in 2015: x-raying the wrong body part and failing to follow physician orders; taking incorrect images and failing to report this to management; and performing the wrong examination on a patient and not following physician orders.

22. The Respondent's file also states that multiple staff members expressed concerns about the Respondent's unprofessional workplace behavior. Staff variously described the Respondent as "a loose cannon," "intimidating," "creepy," "vindictive" and a "bully." Staff reported that they were fearful to report their concerns about the Respondent out of fear of retaliation. One staff member reported witnessing the Respondent send sexual text messages to women and asking for pictures of their breasts.

23. Board staff interviewed the Respondent's supervisor, who stated that his workplace relationship with the Respondent became "very contentious." The supervisor stated that Facility B had investigated the Respondent for failing to report that he had x-rayed the wrong body part and placing the images under the incorrect patient. The supervisor counseled the Respondent numerous times about Facility B's protocol and it came to a point when he did not feel comfortable meeting with the Respondent alone due to the Respondent's acting erratically and aggressively during such meetings. The supervisor stated that multiple staff members complained that the Respondent went missing for hours during his shift and staff was not able to contact him. In addition, the supervisor stated that staff reported to him that the Respondent made them feel "uncomfortable" and

described him as “creepy” and “touchy-feely.” Staff reported that they were afraid to report their concerns out of fear that the Respondent would retaliate against them.

***Misrepresentations on 2017 renewal application***

24. On March 14, 2017, the Respondent filed an application with the Board to renew his radiography license. On this application, the Board asked the Respondent to answer “YES” or “NO” to a series of “Character and Fitness” questions pertaining to the period since April 30, 2015. Among other questions, the Board asked the following:

QUESTION (e):

Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?

QUESTION (O):

Have you voluntarily resigned or terminated a contract from any hospital, HMO, other health care facility, health care provider, or institution, armed services or the Veterans Administration while under investigation by that institution for disciplinary reasons?

25. The Respondent answered “NO” to both questions and certified at the conclusion of his application that his responses were true and correct.

26. The Respondent failed to disclose that he resigned from Facility B in lieu of termination of employment while under investigation by Facility B for performance and behavioral issues.

**Facility C**

27. Board staff obtained the Respondent’s personnel file from Facility C, which had employed him as a radiographer from 1999 to 2019. Facility C’s personnel file states that it terminated the Respondent’s employment on July 3, 2019, for “failing to perform

the requested x-ray [of a patient], exposing the patient to unnecessary radiation, not reporting the error that happened, lying about the reason for deleting the image [and] repeatedly lying about what took place.” The file further documents that the Respondent was previously involved in a similar incident in or around May 2019, was “re-educated” and informed that failure to comply with department policies could result in corrective action.

### *Interview of the Respondent*

28. Board investigators interviewed the Respondent on December 27, 2019, regarding the above matters. When commenting on his work record, the Respondent stated that he had “a great history for the past 25 years” and a “perfect record.” The Respondent admitted that when he applied for employment at Facility D, he did not disclose to Facility D that Facilities A and C had terminated his employment. When responding to questions regarding allegations from female patients and a co-worker that he sexually harassed them, the Respondent either denied the allegations outright or claimed that he was merely “joking” when propositioning them. The Respondent claimed that the patients “took it in the wrong way.” When responding to questions about the Respondent’s accessing of a series of “dating” websites and engaging in on-line chats with women on his workplace computer, the Respondent stated that he did not do so for himself but merely did so for “one of [his] friends.” The Respondent, however, did admit to chatting with women through Gmail. The Respondent concluded his interview by stating,

All I want to say to everyone is that, you know, whatever the situation is with this—people saying staff, that, you know, I never – jokingly. My comments were not, you know – it was just friendly, not taken –

it should not be in a sexual manner or anything like that. I never treated patients, you know, that I felt that, you know, I needed to go that far to say anything because I'm professional. I've been in this field for 25 years, and I want to, you know, be honest with everybody.

And I should have mentioned to [Facility C] and I should've mentioned to [Facility D] that, you, know, I was terminated.

### CONCLUSIONS OF LAW

Based upon the findings of fact, Panel A concludes that the Respondent: fraudulently or deceptively obtained or attempted to obtain a license, in violation of Health Occ. § 14-5B-14(a)(1); is guilty of immoral and unprofessional conduct in the practice of radiography, in violation of Health Occ. § 14-5B-14(a)(3); willfully made or filed a false report in the practice of radiography, in violation of Health Occ. § 14-5B-14(a)(10); and engaged in sexual misconduct, in violation of COMAR 10.32.17.03, *see* Health Occ. § 1-212.

### ORDER

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

**ORDERED** that the Respondent's license (License Number R04432) to practice radiography in Maryland is **REVOKED**; and it is further

**ORDERED** that the summary suspension of the Respondent's license, issued by Panel A on January 28, 2020, is terminated as moot; and it is further

**ORDERED** that the effective date of the Consent Order is the date the Consent Order is signed by the Executive Director of the Board or her designee. The Executive

Director or her designee signs the Consent Order on behalf of the disciplinary panel which has imposed the terms and conditions of this Consent Order; and it is further

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

06/03/2020  
Date

***Signature on File***

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

### CONSENT

I, Dilshad Khan, acknowledge that I have consulted with counsel before signing this document.

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

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

I acknowledge the validity and enforceability of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive protections. I acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order. I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.



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

5/29/20  
Date

***Signature on File***

Dilshad Khan

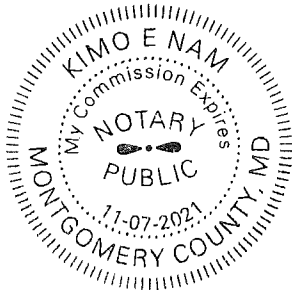
**NOTARY**

STATE OF: MD

CITY/COUNTY OF: Montgomery

I HEREBY CERTIFY that on this 29 day of May, 2020, before me, a Notary Public of the State and City/County aforesaid, personally appeared Dilshad Khan and made oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.



[Signature]  
Notary Public

My commission expires: 11/07/2021