IN THE MATTER OF	*	**BEFORE THE**
SANJAY SANKHE, RADIOGRAPHER	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: R08590	*	**Case Number: 2221-0134 B**

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CONSENT ORDER

On May 9, 2022, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") charged **SANJAY SANKHE, Radiographer** (the "Respondent"), License Number R08590, under 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. and 2020 Supp).

Panel B charged the Respondent with violating the following provisions of Health Occ. § 14-5B-14:

> (a) Subject to the hearing provisions of §14-405 of this title, a disciplinary panel, on the affirmative vote of a majority of the 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:
>
> (4) Is professionally, physically, or mentally incompetent; [and]
>
> (18) Fails to meet appropriate standards for the delivery of quality radiation therapy, radiography, nuclear medicine technology, or radiology assistance care performed in any outpatient surgical facility, office, hospital or related institution, or any other location in this State[.]

On June 22, 2022, Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on the 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 B makes the following findings of fact:

I. BACKGROUND

1. At all times relevant hereto, the Respondent was and is licensed to practice radiography in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on September 6, 2007, under License Number R08590. The Respondent's license is currently active and scheduled to expire on April 30, 2023. The Respondent also holds a radiologic technologist license in Virginia.

2. Until approximately April 2021, the Respondent practiced radiography at various medical imaging centers in Maryland, most recently at an outpatient medical imaging center in Baltimore County, Maryland (the "Center").[1]

II. THE COMPLAINT

3. On or about April 13, 2021, the Board received a Mandated 10-Day Report[2] (the "Complaint") from the management of the Center stating that the Respondent had been terminated "for performance" effective April 9, 2021.

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[1] For confidentiality and privacy purposes, the names of individuals and health care facilities involved in this case are not disclosed in this document.

[2] *See* Health Occ. § 14-5B-15(a) "... employers shall [within 10 days] file with the Board a report that the hospital, related institution, alternative health system, or employer limited, reduced, otherwise changed, or

III. BOARD INVESTIGATION

4. Based on the Complaint, the Board initiated an investigation under case number 2221-0134 B.

5. As part of its investigation, the Board's Investigator requested a written response to the Complaint from the Respondent. The Investigator also obtained relevant medical and personnel records from the Respondent's previous workplaces and conducted interviews with relevant witnesses including the Respondent's previous supervisors, colleagues, and the Respondent himself.

Respondent's Written Response

6. According to the Respondent's written response to the Complaint, the Respondent has worked for approximately 14 years as a radiographer in Maryland, and started his employment at the Center in February 2021 as a computerized tomography (CT) Technician. This role was outside the Respondent's previous professional experience as an x-ray (radiograph) technician, and he was trying to "develop new skills" on this "entirely new modality."

7. The Respondent blamed his termination on an incident that occurred just before his separation, when he attempted to perform a CT angiogram on a patient using intravenous (IV) contrast solution. Regarding this procedure, the Respondent acknowledged being a "novice" and failed to successfully mark the iliac artery with contrast, which led to an inconclusive CT scan because of the Respondent's failure to

terminated any licensee for any reason that might be grounds for disciplinary action under § 14-5B-14 of this subtitle."

highlight the artery properly. The Respondent stated that after he reported the event to his supervisor (the "Center Supervisor"), he was terminated.

8. The Respondent denied that the incident indicates that he is professionally incompetent, citing his "successful career thus far."

Respondent's Tenure as a Radiographer at the Montgomery County Hospital (2015-2017)

9. The Board obtained records from the Respondent's previous employers, including a hospital in Montgomery County (the "Montgomery County Hospital"), where the Respondent work as a PRN imaging technologist performing radiographs from approximately September 2015 until September 2017.

10. The records reveal that the Respondent's initial 90 probation period was extended due to an evaluation indicating that he was failing to meet performance standards in the category of "general job knowledge" after 90 days. Specifically, his supervisor noted that the Respondent needed "to avoid repeats, … familiarize himself with all the diagnostic equipment in the department, [and] learn department workflow."

11. The Board Investigator conducted a sworn interview with the director of medical imaging at the Montgomery County Hospital (the "Director") and the Respondent's immediate supervisor (the "Supervising Tech").

12. The Director stated that from the beginning, the Respondent's images were "very poor." The Director also noted that the Respondent "didn't know anatomy at all."

13. The records and interviews also show that the Respondent was responsible for two x-ray misadministrations, which required reports to be filed with the Maryland

Department of the Environment. In both cases, the Respondent attempted to "hide the fact that he had created an error" and failed to accept responsibility.

14. The first incident involved imaging the wrong body part of a patient, which the Respondent then attempted cover up by attempting to delete the mistaken images from the computer records system. The Respondent also failed to report either incident to a supervisor, as required.

15. In the first case, the Respondent's error and his attempt to cover it up were later uncovered by routine QA audit, and the Respondent was counseled and disciplined.

16. The second incident involved the Respondent x-raying the wrong patient. This time, the Respondent lied about his error to the Supervising Tech in order to hide it. However, the Supervising Tech suspected a misadministration, and immediately confirmed the error himself.

17. Following the second incident, the Respondent was terminated due to "unsafe patient practices."

Respondent's tenure as a CT Technologist at the Center (2021)

18. Contrary to the Respondent's description of a single incident resulting in his termination from the Center, personnel records obtained from the Center demonstrate that the Respondent consistently failed to perform his role as required throughout the several weeks he was employed there.

19. For example, in response the Respondent's unemployment compensation claim, made after his termination, the Center representative listed the reason for his

discharge as "due to repeated errors and unsatisfactory performance," and cited the following specific incidents:

a. March 18, 2021 -- "[Respondent] made an error in entering a patient's medical history."

b. March 24, 2021 -- "Received a patient complaint about [Respondent] telling the patient she was there for a different procedure than she was scheduled for." According to records, the Respondent repeatedly insisted to a patient that she was to receive a chest CT, when in reality, she was to receive a pelvis CT scan.

c. March 29, 2021 – "[Respondent] poorly scanned a patient resulting in 6 errors." According to records, the Respondent was attempting to scan a temporal bone, but poorly positioned the patient's head, performed the scan at an incorrect angle, took 49 images before hitting the proper anatomy, and took 39 images off-target.

d. March 31, 2021 – "[Respondent] poorly scanned a patient resulting in 4 errors."

e. April 7, 2021 ("final incident") – "[Respondent] did not follow policies and procedures while scanning a patient. He was prepped by the lead technologist prior to the scan, he called for guidance several times during the scan, and it was ultimately not performed correctly."

20. The Respondent's personnel file from the Center is replete with documentation of the Respondent's clinical errors, remedial counseling, and failures to make necessary efforts to improve his performance.

21. A final note from the Center Supervisor, written April 8, 2021, sums up the Respondent's tenure at the Center:

> At this point, we are not making any progress with Sanjay. He does not know basic cross-sectional anatomy. He cannot pick out structures like a gallbladder or arch of the aorta. … Sanjay had 6 dedicated weeks of training to learn the scanner. We are now in week 8. He over scans (over radiates) patients because he does not know anatomy. I have meet (*sic*) with him multiple times to address issues. We cannot let him continue in the clinical setting. He is not making progress and patient care is suffering.

22. Of note, the Respondent's personnel records also show that the Respondent himself was aware of his inadequate abilities. On self-evaluation form he was asked to complete, the Respondent judged that he was only able to satisfactorily and independently perform 8 out of 27 types of clinical examinations listed. He judged himself as needing improvement in:

a. Evaluating exam order;

b. Technologist safety/IV skills;

c. Equipment warm up and QA; and

d. Most areas of post processing.

23. Sworn interviews with the Center Supervisor as well as the Respondent's immediate supervisor (the "Immediate Supervisor") confirmed the personnel records' documentation of the Respondent's failures to meet requirements or substantially improve during his tenure at the Center, despite their best efforts to train him.

The Respondent's Tenure as a CT Technologist at the Baltimore County Hospital (2021)

24. Following his termination from the Center, the Respondent gained employment at a hospital in Baltimore County (the "Baltimore County Hospital"), where he worked as a CT Technologist from approximately May 17, 2021 until June 24, 2021, when he was terminated due to unsatisfactory performance.

25. According to records obtained from the Baltimore County Hospital, the Respondent was terminated because he was unable to meet

> the minimal performance expectations of a CT technologist within the [imaging] department. Sanjay has not demonstrated that his skillset would allow him to work independently as a technologist in CT. We have worked with Sanjay to give him an extended amount of training, however, there has (*sic*) been no improvements. Some of the performance issues that have been raised with Sanjay, include instances that could result in patient safety issues.

26. The records also demonstrate that the Respondent was counseled.

27. According to the Imaging and Operations Manager at the Baltimore County Hospital, who supervised the Respondent (the "Manager"), the Respondent lacked knowledge of "basic anatomy that a new graduate would know." Therefore, the "pertinent anatomy was missing a lot of times" on the scans produced by the Respondent.

28. The Manager also stated the Respondent lacked a "basic understanding of CT and how a CT scanner works" and was unable to perform his duties independently.

29. The Manager also shared her concern regarding an incident in which the Respondent mistakenly caused a patient IV line to become dislodged, and then attempted

to hide his mistake by covering the affected area with a bedsheet, and later denying responsibility.

CONCLUSIONS OF LAW

Based on the forgoing Findings of Fact, Panel B concludes as a matter of law that the Respondent: is professionally, physically, or mentally incompetent, in violation of Health Occ. § 14-5B-14(a)(4); and failed to meet appropriate standards for the delivery of quality radiation therapy, radiography, nuclear medicine technology, or radiologist assistance care performed in any outpatient surgical facility, office, hospital or related institution, or any other location in this State, in violation of Health Occ. § 14-5B-14(a)(18).

ORDER

It is, thus, by Disciplinary Panel B of the Board, hereby:

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

ORDERED that the Respondent's license to practice radiography is **SUSPENDED**[3] until the Respondent has successfully complied with the following conditions:

(1) The Respondent shall enroll in the **Maryland Professional Rehabilitation Program (MPRP)** as follows:

(a) Within **5 business days,** the Respondent shall contact MPRP to schedule an initial consultation for enrollment;

[3] If the Respondent's license expires during the period of suspension, the suspension and any conditions will be tolled.

(b) Within **15 business days,** the Respondent shall enter into a Participant Rehabilitation Agreement and Participant Rehabilitation Plan with MPRP;

(c) the Respondent shall fully and timely cooperate and comply with all MPRP's referrals, rules, and requirements, including, but not limited to, the terms and conditions of the Participant Rehabilitation Agreement(s) and Participant Rehabilitation Plan(s) entered with MPRP, and shall fully participate and comply with all therapy, treatment, evaluations, and screenings as directed by MPRP;

(d) the Respondent shall sign and update the written release/consent forms requested by the Board and MPRP, including release/consent forms to authorize MPRP to make verbal and written disclosures to the Board and to authorize the Board to disclose relevant information from MPRP records and files in a public order. The Respondent shall not withdraw his release/consent;

(e) the Respondent shall also sign any written release/consent forms to authorize MPRP to exchange with (i.e., disclose to and receive from) outside entities (including all of the Respondent's current therapists and treatment providers) verbal and written information concerning the Respondent and to ensure that MPRP is authorized to receive the medical records of the Respondent, including, but not limited to, mental health and drug or alcohol evaluation and treatment records. The Respondent shall not withdraw his/her release/consent;

(f) the Respondent's failure to comply with any of the above terms or conditions including terms or conditions of the Participant Rehabilitation Agreement(s) or Participant Rehabilitation Plan(s) constitutes a violation of this Consent Order;

(2) During the suspension, the Respondent shall not:

(a) practice radiography;
(b) take any actions to hold himself out to the public as a current provider of radiography services;
(c) authorize, allow or condone the use of the Respondent's name or provider number by any health care practice or any other licensee or health care provider;
(d) function as a peer reviewer for the Board or for any hospital or other medical care facility in the State;
(e) perform any other act that requires an active radiography license; and it is further

(3) The Respondent shall take and successfully complete courses in: (i) **general radiography,** (ii) **anatomy and physiology,** and (iii) **professional ethics.** The following terms apply:

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

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

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

(d) the Respondent is responsible for the cost of the courses; and

(4) After the Respondent has successfully completed the courses required under suspension condition (3), if MPRP finds, and notifies the Board, that the Respondent is safe to return to the practice of radiography, the Respondent may submit a written petition to Panel B to terminate the suspension of the Respondent's license. The Respondent may be required to appear before Panel B to discuss his petition for termination. If panel B determines that it is safe for the Respondent to return to the practice of radiography, the suspension will be terminated through an order of the Panel B, and Panel B may impose any terms and conditions it deems appropriate on the Respondent's return to practice, including, but not limited to, probation and continuation of the Respondent's enrollment in MPRP. If Panel B determines that it is not safe for the Respondent to return to the practice of radiography, the suspension shall be continued through an order of the disciplinary panel for a length of time determined by the disciplinary panel, and the disciplinary panel may impose any additional terms and conditions it deems appropriate; and it is further

ORDERED that, upon the termination of suspension, the Respondent **shall not practice CT (computed tomography) technology for** a minimum period of **FIVE YEARS.** The following terms apply:

a. On every January 31st thereafter, if the Respondent holds a Maryland radiography license, the Respondent shall provide the Board with an affidavit verifying that the Respondent has not practiced CT technology in the past year;

b. If the Respondent fails to provide the required annual verification of compliance with this condition:

1. There is a presumption that the Respondent has violated this condition; and

2. The alleged violation will be adjudicated pursuant to the procedures of a Show Cause Hearing.

c. After a minimum period of **FIVE YEARS** from the termination of the suspension, the Respondent may submit a written petition to the Board showing good cause as to why he should be permitted to resume the practice of CT technology. In its discretion, after consideration of the petition, the petition may be granted or denied through an order of a Board disciplinary panel; and it is further

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

ORDERED that, if the Respondent allegedly fails to comply with any term or condition imposed by this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If the disciplinary panel hearing the matter determines there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings followed by an exceptions process before a disciplinary panel; and if the disciplinary panel determines there is no genuine dispute as

to a material fact, the Respondent shall be given a show cause hearing before a disciplinary panel; and it is further

ORDERED that, after the appropriate hearing, if the disciplinary panel determines that the Respondent has failed to comply with any term or condition imposed by this Consent Order, the disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke the Respondent's license to practice radiography in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on the Respondent; and it is further

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

07/21/2022
Date

Signature On File

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

CONSENT

I, Sanjay Sankhe, Radiographer, 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.

Signature On File

7/14/22

Date

Sanjay Sankhe, Radiographer

NOTARY

STATE OF Maryland

CITY / COUNTY OF Baltimore

I HEREBY CERTIFY that on this 14th day of July 2022, before me, a Notary Public of the foregoing State and City/County, personally appeared Sanjay Sankhe, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

DANIELA P. SANCHEZ ZUNIGA
Notary Public - Maryland
Baltimore City
My Commission Expires
07/08/2024

Notary Public

Commission expires: